DOCUMENT RESUME

ED 152 794 TM 006 888

TITLE A Report on the National Health Service Corps Preceptorship Project. Final Report-Part III.
INSTITUTION American Medical Students Association Foundation, Rolling Meadows, Ill.
SPONS AGENCY Health Resources Administration (DHEW/PHS), Bethesda, Md. Bureau of Health Manpower.
PUB DATE 30 Sep 76
CONTRACT BHM-231-75-0606
NOTE 75p.; For related documents, see TM 006 886 and 887

EDRS PRICE MF-$0.83 HC-$3.50 Plus Postage.
DESCRIPTORS Admission Criteria; Career Choice; *Clinical Experience; Evaluation Criteria; *Field Experience Programs; *Geographic Regions; Higher Education; *Manpower Needs; *Medical Students; Primary Health Care; Program Administration; *Program Descriptions; Program Evaluation; Questionnaires; Site Selection; Specialization; Student Placement; Student Recruitment
IDENTIFIERS National Health Service; *Preceptorship

ABSTRACT

In May 1975, the American Medical Student Association Foundation began the development of a primary care preceptorship program for medical and osteopathic students in National Health Service Corps (NHSC) communities. The goals of the preceptorship program were to (1) provide experience in the delivery of primary care in a health manpower shortage area in order to attract them to primary care specialties in similar locations; (2) to involve the NHSC assignees in the educational process; (3) to assist NHSC assignees in establishing academic linkage and clinical backup for their practices; (4) to increase the number of potential future health providers for NHSC programs; and (5) to evaluate the preceptorship program. The program administration, development, operation, and evaluation are discussed. The appendices include the preceptorship site assessment instruments, a list of sites and the number of student participants for each program cycle, the educational guidelines for the program, a description of the evaluation methodology, and the evaluation instruments. (Author/BW)

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A Report on the National Health Service Corps Preceptorship Project

Submitted by the

American Medical Student Association (AMSA) Foundation

FINAL REPORT - Part III

BHM Contract No. 231-75-0606

TM006 888

September 30, 1976

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I. Site Assessment Instruments

II. List of Sites and Number of Student Participants for Each Program Cycle

III. Educational Guidelines

IV. Evaluation Methodology and Instruments

I. INTRODUCTION

In May 1975 the AMSA Foundation was awarded a contract by Bureau of Health Manpower (HRA/DHEW) to (1) develop a primary care preceptorship program for medical and osteopathic students in National Health Service Corps communities and (2) to perform a feasibility study for tracking medical and osteopathic students participating in preceptorship programs. The two above activities were termed "Mission A" and "Mission B" of the contract, respectively. This report will focus on Mission A. The final report of Mission B will be submitted separately.

The goal of the preceptorship program was to place 150 medical and osteopathic students into selected NHSC sites to meet the following objectives:

1) To provide the students experience in the delivery of primary care in a health manpower shortage area in order to reinforce their interest in or attract them into primary care specialties and to impact on their eventual practice location preferences;

2) To involve the National Health Service Corps in the educational process of health science students;

3) To assist NHSC assignees in establishing academic linkage and clinical backup for their practices;

4) To build up a resource of potential future health providers for the NHSC programs;

5) To evaluate the preceptorship program.

In fact, 162 medical and osteopathic students were placed within the time period of the contract (at no additional cost). Students were recruited and selected on a nationwide basis, and sites in a total of 38 states were utilized throughout the program. A total of 5 program cycles was held (Summer and Fall 1975; Winter, Spring and Summer 1976) over a 17 month period; individual student preceptorships ranged from 4 to 12 weeks within these cycles. In addition to the preceptorship program itself and its related activities, additional tasks were performed pursuant to the overall intent of the contract - these are described in Section V of this report.

A discussion of the various areas of performance related to the preceptorship program follows.

II. PROGRAM ADMINISTRATION

A. Staff

Overall responsibilities for the preceptorship program were assumed by Sandra Smith, Director for the AMSA Foundation's Center for Medical and Interdisciplinary Student Programs. Ms. Smith (whose time was provided by the AMSA Foundation at no direct cost to the program) was highly involved in all aspects of coordination and development, including criteria for sites, preceptor and student selection; recruitment mechanisms; curriculum; orientation and debriefing; evaluation; overall contract management; additional activities (i.e., preparation,

with Dr. Naomi Quenk, of a guide to developing primary care preceptorships and work with staff of Student National Medical Association and National Chicano Health Organization to develop a common protocol for evaluation of preceptorship programs).

Two Field Coordinators, Ms. Mary C. Hanna and Mr. Robert Stocking and the program secretary performed work related to identification, recruitment and selection of program sites, preceptors and preceptees; site development; individual site and program evaluation; support during program operation; development of academic support systems at medical and osteopathic schools in proximity to program sites; conduct of orientations and debriefings.

Early in the program, it was determined that to prepare an evaluation protocol of the scope and complexity necessary to evaluate the program effectively, the services of a skilled professional would be required. Accordingly, Naomi Quenk, Ph.D. was employed to develop and conduct the program evaluation. Dr. Quenk had formerly been a member of the University of New Mexico Longitudinal Research Group and was extremely well qualified in the area of evaluation. In addition to the preceptorship evaluation, Dr. Quenk was the primary author of the "Guide to Developing Primary Care Preceptorships" which will be described later in this report.

B. Advisory Committee

In order to obtain input into program development of the various groups of program participants, an Advisory Committee was formed to oversee general program development and operation. Members of the committee included Debbie Thoma, Michael Jason and Robert Gardner, preceptees; Drs. Hal Moessner (University of Iowa) and Ross Lawler (University of Texas - San Antonio), academic advisors; Dr. George Shannon, NHSC preceptor; Anna Barish and Martha Evans, Bureau of Health Manpower representatives; and project staff. The Advisory Committee reviewed and offered input into components of the program such as selection and matching criteria, program guidelines, orientation and debriefing mechanisms, evaluation protocol. The committee participated in one formal meeting in November 1975 and provided additional input and resources to the project where appropriate.

C. Contractual Changes

As the program progressed, revisions in certain operational areas were considered advantageous to success of the program and were negotiated with and approved by the federal Project and Contract Officers. Included in these were the following:

1) Extension of the program through September 30, 1976 - originally, 150 students were to have been placed during the period May 1, 1975 through August 30, 1976. However, due to the effective commencement date of the contract, inadequate time was available for the initial cycle to identify, select and develop a sufficient number of appropriate NHSC sites and to recruit

student participants (many of whom had already made other summer plans). Because a majority of medical students are able to participate in preceptorship programs more easily during the summer months, the program was extended through the summer of 1976 to ensure the required number of student participants would be placed.

2) Length of program - originally, the minimum length for a student's preceptorship program was set at six weeks. However, after the initial program cycle, students expressed their concern at the six week minimum because of the four week time periods for curricular electives allowed by many medical schools. These students also felt that while a program which allowed an individual to experience adequately and integrate concepts of primary care could hardly be obtained in less than eight or nine weeks, a program to expose students to the concepts of primary care in a community setting could reach its objectives in a four week period. Because students in a traditional academic medical center frequently lack any kind of exposure to primary care, the students felt it extremely important that we offer an opportunity for students to obtain this exposure. Accordingly, the Advisory Committee reviewed the preceptees' feedback and recommended to the Project Officer that a minimum four week experience be allowed. This proposal was subsequently adopted.

3) Academic Triage Officer - in the original concept of the educational triage support system, it was anticipated that the triage advisors located in medical schools near program sites would visit each site

during a student's program. Purposes for the visit would include monitoring and evaluating the preceptorship experience and establishing a link with the NHSC physician. After the initial project cycle, feedback from student participants, from preceptors and from project staff who had been present at the site visits indicated that this concept was not always productive. Physicians often had other mechanisms for referral and did not need an advocate within the medical center. Many of the students, who were receiving elective credit from their schools and being monitored by their schools, felt that a visit from the triage advisor was unnecessary. In other cases, both physician and student felt the introduction to a faculty member was beneficial. The Advisory Committee reviewed all input and decided that rather than attempting to have triage officers visit each site during each student's preceptorship, utilization of the concept should relate to a need identified either by the student or by the preceptor. (In addition, the term "triage officer" was changed to "academic resource person". Other activities of these persons will be discussed in the next section.)

III. PROGRAM DEVELOPMENT AND OPERATION

A. Site and Preceptor Selection

A major effort throughout the program was to identify NHSC and shortage area sites that would be appropriate for the program. Criteria for selection of sites and preceptors were developed by program staff in

May of 1975 and were reviewed by federal Project Officers Jaime Manzano and Shirley Johnson and by additional consultants to the Bureau. Based on the input obtained, criteria were revised during the summer of 1975. Final criteria were as follows:

-Manpower needs and priorities of the Corps, as related to NHSC region;

-Adequate physical space to accommodate students in the site's clinic;

-Tenure of NHSC assignee(s) - also related to arrival and departure dates of the assignee and whether one or more physicians are "ongoing" during turnover in personnel;

-Regional Program Consultant approval of the site;

-Community Board approval of preceptorships;

-Attitudes and experience of NHSC site personnel re: interest and willingness to have student participation;

-General community receptivity to student involvement;

-Nature of work opportunities available, both within and outside the preceptor's practice (e.g., student community-related projects, experiences in other parts of the delivery system);

-Ability and willingness of NHSC site personnel to establish liaison with a regional medical school for interaction with faculty from a primary care department, for purposes of program consultation and student evaluation;

-Practice model in use at site (e.g., physician extenders, team approach);

-Existing of planned linkage with medical resource/support centers (e.g., AHEC, medical training centers, National Library of Medicine);

-Compatability between objectives and expectations of site personnel in the program;

-Willingness of preceptors to abide by educational objectives and guidelines.

Field staff worked closely with NHSC Regional Program Consultants and with site personnel to ensure an adequate understanding of the program on the part of these persons and to select sites which would offer the best experience for the students. Virtually all program sites were visited at least once by the field coordinators, either prior to or during the initial student's placement, to orient the physician and community to goals and operation of the project. A number of forms were developed for staff use in determining whether or not a particular community would be an appropriate place for students; these are included in Appendix I. Certain of the information was obtained prior to a decision as to whether the site would be utilized; additional information was obtained at the time of the site visit by field coordinators.

During the final project cycle (summer 1976) a tremendous surplus of student applications over available program sites was received. Program staff discussed the situation with Anna Barish, Federal Project Officer, and it was determined that in addition to NHSC communities, other BHM-determined manpower shortage areas could be utilized. Accordingly, several students were placed on non-NHSC sites during that cycle.

B. Preceptee Recruitment and Selection

Efforts to inform students of the preceptorship program and to recruit them for participation continued throughout the entire project period. Field coordinators visited a large number of medical and osteopathic

schools to present the program both to students and to faculty who could advocate elective credit. In addition, literature was distributed to students on a national basis, both by project staff, via AMSA Chapters, and by former project preceptees and academic resource personnel.

As with the site selection criteria, initial student selection criteria was developed by staff and subsequently reviewed by federal personnel. Considerable discussion was held related to whether criteria should be fairly stringent and should require specific evidence of an interest in primary care, or whether the criteria should contain a minimum of essentials in order to "turn on" students who feel they might have an interest in this type of practice, but had not had an opportunity for any type of primary care-related experience. The final criteria followed the latter line of thought - i.e., that students should be able, in a program such as this, to be exposed for the first time to practice in shortage areas. In addition, of course, the program would involve students who already had a definite interest in primary care and wanted an additional experience in this type of practice. The student selection criteria for the project was divided into "essentials" and "additional points of consideration", as follows:

Essentials

-Must have had physical diagnosis or equivalent experience;

-Preferably have completed two years of school or the equivalent;

-Available for a minimum of six weeks; preferably nine weeks.

Additional Points of Consideration

-Activities pursued by the student during free time after freshman year (if applicable);

-Interest in primary care practice;

-Background characteristics, to include:

·Size of community where the student grew up;
·Spouse's profession;
·Past experience in community-based projects;

-Student interest in participating in one of the areas of the most critical need;

-Desired practice location of the student;

-Married students with spouse who will accompany them will take preference over married students whose spouses will not accompany them.

C. Student and Site Matching Criteria

Again using the review process described above, student and site matching criteria were established, as follows:

-No more than two students at a site at any given time;

-Number of student participants will relate to size of staff;

-Profession of student will relate to profession of staff (e.g., osteopathic students placed with D.O.);

-Attempt will be made to correlate special clinical interests of preceptor and preceptee;

-Students requesting placement in home states or home sites will receive priority consideration;

-Level of student training will be related to patient population characteristics, such as load, community epidemiology;

-Site expectations and student expectations will correlate related to amount of precpetee time to be spent in clinical and non-clinical activities.

-Geographical preference of student, as related to location of school, background, and anticipated practice location, will relate to placement at a particular site;

-Concurrence of student and preceptor on the match.

Whenever possible, students were placed at program sites in proximity to their educational institutions. It was believed that by placing students nearby, support systems between the site and the institution could be set up more easily, to the benefit of both student and preceptor. As the program progressed, however, it became apparent that a majority of student applicants were from Eastern medical schools, apparently due to the lack of remote site primary care experiences available to these students through their institutions. A good number of the students had to be placed in other parts of the country, due to the limited number of appropriate NHSC sites in the East.

Prior to a final decision on student placement, students were sent information about the site and preceptors were sent relevant information about the student applicant. After reviewing this information, students and preceptors engaged in at least one telephone conversation to discuss their respective expectations related to the program and to reach a final decision as to whether the proposed placement was satisfactory to both parties.

A list of program cycles, with number of student participants, sites and dates of placement identified, is contained in Appendix II. Due to

federal regulations relative to the Privacy Act, it was not possible to provide actual names of student participants.

D. Curriculum

Program guidelines were developed to aid both preceptor and student in establishing the edcuational program. The guidelines included overall objectives of the program, responsibilities of the preceptor and the student, and suggested areas of program involvement. It was understood by staff and participants that not all of the suggested activities would be appropriate for individual programs, but student participation in some aspects of clinical involvement, role of the physician, economic determinants of care, interaction with other parts of the health system and community involvement were required.

To ascertain that individual programs were meeting overall project requirements, the student and preceptor were required to set specific educational and service objectives for the experience and to forward these objectives to the project staff for review. Students and preceptors were encouraged to review their activities in terms of the objectives at least once during the preceptorship. The student also was required, at the conclusion of his project, to submit a final report of his activities in terms of the established objectives.

A copy of program guidelines is contained in Appendix III.

E. Program Orientation

Orientation for student participants was accomplished through a variety

of mechanisms. For the initial project cycle (summer 1975) a formal orientation was held at a central location. Participants included not only the students, but selected preceptors, representatives of the Bureau of Health Manpower and the National Health Service Corps, a consultant to provide a workshop for students on defining educational and service objectives, and staff. Included in the orientation sessions were discussions of objectives of the preceptorship program, a workshop in setting educational and service objectives, small group sessions on roles and expectations of the preceptees, preceptors and program staff; discussion, by federal staff, of the philosophy, objectives, and operation of NHSC and BHM; and an overview of the program evaluation.

Subsequent to the summer cycle, a formal orientation session was not possible due to non-uniform starting dates for the individual programs because of varying academic schedules. In order to orient students effectively, a project handbook was developed which included most information incorporated into the formal summer orientation. In addition, students were provided information on their communities and, as stated previously, required to discuss the project with their prospective preceptor prior to a final match. Project staff also discussed expectations and program operation with the students in detail before their program began.

Preceptors were oriented to the program per information sent to them (e.g., program guidelines) and during the site visit made by field coordinators. At least one telephone conversation was held with the preceptor by project

staff prior to the initial student's placement to make certain the preceptor understood his responsibilities and expectations of both himself and the student.

F. Infield Support

Support during the preceptorship program was provided in a number of ways by program staff. These included:

-Site visits made by program staff to discuss the experience with both student and physician and to provide assistance in locating additional resources, where requested;

-Telephone conversations with students and/or preceptors early in the project to answer any questions, discuss expectations or problems, and identify/provide additional resources requested;

-Identification of an academic resource person at a nearby medical center to make a site visit (where requested by student or preceptor). In addition, this person could perform such services as sending information from the medical library, identifying a consultant for a specific clinical problem, etc.

G. Debriefing

After each cycle of the project, a debriefing was held at a central location for student participants and a few selected preceptors. Purpose of the debriefings encompassed two areas: (1) to provide an opportunity for students to share their preceptorship experience with other preceptees and with staff, to define problem areas, to have questions answered, to evaluate program operation as it affected their experience; (2) to enable

staff to obtain anecdotal information about the sites and the various experiences (including information of great value that students would be reluctant to put into writing), to obtain from students specific recommendations on how the project might be changed to improve the experience, to obtain suggestions on program operation and to encourage the preceptees to recruit their fellow students for future cycles. The debriefings provided the major source of information and recommendations for effective programmatic and operational changes.

IV. EVALUATION

A formal evaluation designed to provide certain background and personality characteristics of preceptees and preceptors, as well as to assess outcomes of the experience, was developed for the project and subsequently approved by federal program officers. The evaluation methodology and instruments are contained in Appendix IV. In addition, evaluations of program operation, informational materials, selection and matching procedures, etc. were obtained during the entire course of the program and utilized in an action-research model to make appropriate changes during the course of the project.

A formal evaluation report will not be submitted as a part of this final report. Due to the AMSA Foundation's award of Contract #231-76-0070, which is in effect a continuation of this program and which utilizes the same evaluation techniques, the evaluation data will be processed simultaneously for student and preceptor participants under both contracts. Thus, the formal report will be submitted in June 1977 at the conclusion of Contract #231-76-0070. However, it is the AMSA Foundation's intent to

provide a preliminary assessment of data on this contract's students in November 1976.

V. OTHER ACTIVITY

A. Collaboration with the Student National Medical Association and the National Chicano Health Organization to develop certain common data elements for evaluation, as required by original contract scope of work, was accomplished during the summer and fall of 1975. Several meetings were held with federal representatives and staff of the three contractors as participants. The final meeting to define the common data elements was held in November 1975. The representative of the Student National Medical Association, who had been designated chairperson for this group, was to submit the final recommendations to federal program officers.

B. A guide to developing primary care preceptorships has been developed by Naomi Quenk and Sandra Smith. As the project progressed, it became evident that a great deal of expertise existed throughout the academic medical world in how to design and operate preceptorship programs. Unfortunately, while each of nearly 100 individual preceptorship programs had its own guidelines, no manual existed to assist prospective preceptorship developers in benefitting from others' experience. Input into the guide was obtained both from an intensive review of information, both published and unpublished, on existing preceptorships and with several consultants involved currently in established programs. The guide will be published under auspices of the AMSA Foundation and will be made available to any interested persons.

SAMA/NHSC PRECEPTORSHIP PROJECT

SITE PROFILE

RPC _____

COMMUNITY _____

FIELD VISIT _____

SITE _____ COUNTY _____

TOWN _____ POPULATION _____

STATE _____ REGION _____

OPENED _____ WILL CLOSE _____

COUNTY (Service Area) POPULATION _____ PATIENT LOAD _____

NO. OF PHYSICIANS ALLOTED TO SITE _____ PATIENT/PHYSICIANS RATIO _____

STAFF	DISCIPLINE/SPECIALTY	ARRIVED	WILL LEAVE

NON-NHSC HEALTH-CARE PERSONNEL:

MD'S/DO'S _____ DDS _____ RN _____ OTHER _____

OTHER SUPPORT:

HOSPITAL _____ BEDS _____ DISTANCE _____

OTHER _____

AVERAGE FAMILY INCOME _____ % POVERTY _____ % PUBLIC AID _____

WHITE POPULATION _____ BLACK POPULATION _____ OTHER _____

NATIVE AMERICAN _____ SPANISH SPEAKING _____

UNUSUAL EPIDEMIOLOGY:

_____

_____

PRACTICE MODEL:

_____

_____

SPONSORING COMMUNITY AGENCY:

_____

COMMUNITY CONTACT: Name _____ Phone ( ) _____

PREVIOUS PRECEPTORSHIP PLACEMENTS:

NAME _____ DATES _____

_____ _____

_____ _____

SAMA/NHSC PRECEPTORSHIP PROJECT

SITE PROFILE

SITE _____

STATE _____ REGION _____

1. FACILITY

Patient load, staff time for teaching, adequacy of physical facilities, space for student.

2. PRECEPTOR

Special interests, specialty, board certification.

3. POSSIBLE PROJECTS FOR STUDENTS

SAMA/NHSC PRECEPTORSHIP PROJECT

SITE-PROFILE

SITE _____

STATE _____ REGION _____

4. OTHER PARTS OF HEALTH CARE SYSTEM IN WHICH STUDENT MIGHT BECOME INVOLVED:

5. EXPECTED DISTRIBUTION OF STUDENT'S TIME:

_____ % CLINICAL _____ % NON-CLINICAL _____ % COMMUNITY

6. STUDENT LEVEL OF TRAINING DESIRED

7. HOUSING AVAILABILITY

8. TRANSPORTATION: CAR NEEDED? NEAREST AIRPORT?

SAMA/NHSC PRECEPTORSHIP PROJECT

SITE PROFILE

SITE _____

STATE _____ REGION _____

1. STAFF

Attitude about serving as preceptor, attitudes about NHSC Receptivity to educational guidelines and triage system:

2. COMMUNITY

Receptivity to student; community leadership - capabilities objectives, expectations; relationship with assignee, with RPC; special problems:

3. GENERAL COMMENTS/SPECIAL SITUATIONS

SAMA FOUNDATION/NHSC PRECEPTORSHIP PROJECT

PHYSICIANS' QUESTIONNAIRE

SITE _____

STATE _____ REGION _____

1. Approximately how many patients are served by your site? _____

   How many do you see on an average day? _____

   Do you consider this a: _____ light _____ average _____ heavy load

2. Are you Board Eligible in a Specialty? _____ If yes, which specialty? _____

   If not, in which specialty do you plan to do a residency? _____

3. Do your physicial facilities have adequate space and equipment for you and other staff?

   _____ Yes _____ No

   Would a student assigned to the site have adequate space to work?

   _____ Yes _____ No

4. Describe any special aspects of the epidemiology of your patient population:

   _____

   _____

5. Are there any other special medical aspects of the community which affect your practice?

   _____

   _____

6. Describe the practice model at your site: (Other physicians, nurses, physician extenders, outreach, etc.)

   _____

   _____

7. What health care resources (Hospital, nursing homes) are available to the community? (Size, distance from NHSC site?)

   _____

   _____

8. Which of the above do you work closely with? Would a student have an opportunity to learn about their operations?

   _____

   _____

9. Are you "on call" regularly for emergency room coverage?

   _____

10. Non-NHSC Health Care Personnel serving community (Number and discipline)?

_____

_____

11. How much time do you feel a student assigned to your site would spend in:

_____% clinical activities _____% non-clinical activities _____% community activities

12. What special interests do you have which might be shared with a student? (e.g., medical, recreational, social, etc.)

_____

_____

13. What special health care needs of the community might provide a focus for a student's project during a preceptorship?

_____

_____

14. If a married student were assigned to your site, would the spouse be able to participate in medical, social, and community activities?

_____

_____

15. Other comments which might effect the selection of a student to be matched with your site:

_____

_____

16. Based on the short outline of the proposed educational/support system in the attached material, would you like to participate in such a system?

_____

_____

_____

17. What is the minimum level of training necessary for a student to be assigned to your site?

_____

_____

18. What is your relationship with nearby health care training facilities? Have students or residents spent time at your site as part of their training?

_____

_____

_____

SITE: _____

REGION: _____

DATE: _____

NHSC PRECEPTORSHIP PROGRAM

SITE VISIT REPORT

COMMUNITY & COMMUNITY BOARD

1. Meeting with board person (Explain program)

   NAME & POSITION

   Relationship with Doc, with RPC, and Corps. Opinion and/or receptivity RE: Students Leadership capabilities:

2. Community - (See Above)

   Recreation, economic condition, political and moral climate:

FOR THIS SITE: Follow-up needed

SITE VISIT REPORT

DOCTOR & CLINIC

1. Explain program and objectives and guidelines. Check educational and service objectives, discuss triage needs and possibilities, explain evaluation:

2. CLINIC

   Space and vacilities, location:

3. CLINIC PERSONNEL

   Number, kinds, relationship with Doctor:

4. Relationship with board and community:

5. Relationship with hospital - admitting privileges, emergency calls, referrals:

6. Relationship with medical society, public health dept, other docs:

7. Impact of student - continuing education of Doc; on patients; viability as a teaching site:

SITE VISIT REPORT

STUDENT

1. Discuss education and service objectives; appropriateness and progress; also specific student project:

2. Interaction with other parts of health care delivery system. How much? How often? How good/bad?

3. Interaction with community (as in 2):

4. Preception of Corps, Doc, and site:

5. Problems: Housing, transportation; at time of arrival, now?

6. Orientation: What was good? What was Bad? What was left out?

7. Usefulness of goal setting session and how it went with preceptor?

SUMMER CYCLE - 1975

Number of Student Participants: 38

NHSC Site Utilized	Dates of Student Placement
Maxton, NC	6/30-8/1/75
Marana, AZ	6/23-9/12/75
Orbisonia, PA	7/14-8/22/75
Winona, MO	7/14-8/22/75
Pagosa Springs, CO	6/23-9/12/75
Faulkton, SD	6/30-8/8/75
Surgoinsville, TN	6/30-8/22/75
Yukon, WV	6/30-8/29-75
Eldora, IA	6/23-8/1/75
Unalaska, AK	6/23-8/1/75
Cherokee, AL	6/23-8/15/75
Mound City, KS	6/9-8/29/75
Plymouth, NC	6/30-8/8/75
Spring Mills, PA	6/30-8/8/75
Grand Coulee, WA	6/30-8/22/75
Truchas, NM	6/23-8/15/75
Phoenix, AZ	6/23-8/15/75
Louisburg, KS	6/23-8/29/75
Rio Linda, CA	7/7-8/15/75
Parsons, TN	7/14-8/15/75
Liberty, IN	7/7-8/15/75
White Haven, PA	6/23-8/8/75
Waelder, TX	6/22-8/30/75
Sterling, CO	6/2-8/22/75
Independence, VA	6/30-8/22/75
Etna, CA	6/30-8/22/75
Alexandria, PA	7/14-8/22/75
Island Pond, VT	6/30-8/29/75
White Haven, PA	8/11-9/12/75
Harlingen, TX	7/14-8/29/75
Guernville, CA	6/30-8/15/75
Mt. Benton, MT	7/7-8/29/75
Rocky Ford, CO	6/2-8/22/75
Rushville, IN	7/7-8/15/75
Red Bay, AL	6/30-8/15/75
Brownsville, CA	7/7-8/15/75
Mound City, KS	6/30-8/29/75
Marianna, AR	6/16-8/15/75

FALL CYCLE - 1975

NHSC Site Utilized	Dates of Student Placement
Number of Student Participants: 9	
Onida, SD	8/18-9/26/75
W. Winfield, NY	9/8-10/24/75
Island Pond, VT	9/29-11/28/75
Haysville, NC	10/6-12/20/75
Stevenson, WA	11/3-12/19/75
Pearsall, TX	10/13-12/9/75
Orbisonia, PA	10/13-11/28/75
White Salmon, WA	11/17-1/2/76
Toele, UT	11/3-12/12/75

WINTER CYCLE - 1976

Number of Student Participants: 10	
Toelle, UT	1/5-1/30/76
W. Winfield, NY	1/5-2/27/76
Mound City, KS	12/1-2/28/76
"	12/1-1/20/76
Immokalee, FL	1/5-2/27/76
Vinal Haven, ME	3/1-3/26/76
Panama Beach, FL	2/16-3/19/76
Toledo, IA	12/1-2/27/76
Martin, SD	1/12-2/30/76
Alexandria, PA	12/15-2/6/76

SPRING CYCLE - 1976

Number of Student Participants: 20	
Aurora, NY	3/15-5/14/76
Rocky Ford, CO	3/1-5/3/76
Winona, MO	4/19-6/25/76
Hatch, NM	4/5-5/15/76
Cochrane, WI	5/3-5/28/76
McArthur, OH	4/12-5/7/76
Etna, CA	4/26-6/18/76
2 Vinal Haven, ME	5/3-6/4/76 and 4/19-6/12/76
2 Mound City, KS	3/1-5/12/76 and 3/29-5/31/76
Gallup, NM	4/30-6/15/76
Charlotte, MI	5/3-6/26/76
Bruce, WI	3/1-5/29/76
Orbisonia, PA	3/29-5/7/76
Independence, VA	3/8-4/30/76
Danville, NY	4/12-6/4/76
Mellen, WI	4/26-6/4/76
Parsons, TN	4/5-5/14/76
Panama City, FL	4/19-5/26/76

SUMMER CYCLE - 1976

NHSC Site Utilized	Dates of Student Placement
Number of Student Participants: 85	
Bruce, WI	8/1-8/30/76
Sparta, NC	5/31-7/1/76
Kansas, OK	6/28-8/13/76
Kingwood, WV	6/14-8/7/76
Parsons, TN	6/28-8/27/76
Eldora, IA	8/1-8/30/76
Vinal Haven, ME	6/28-8/1/76
"	8/1-8/28/76
McCormick, SC	7/26-9/3/76
Brookings, OR	6/21-8/22/76
Bailey, CO	5/31-8/13/76
Twisp, WA	6/28-9/8/76
McArthur, OH	6/28-8/27/76
N. Attleboro, MA (Shortage Area)	6/21-8/13/76
Surgoinsville, TN	6/21-7/30/76
Orbisonia, PA	6/21-8/20/76
Homedale, ID	7/12-8/13/76
Waelder, TX	6/22-9/3/76
Craigsville, VA	6/21-7/16/76
Gaylord, MN	7/5-8/21/76
White Salmon, WA	6/21-9/4/76
"	8/30-9/30/76
Riverdale, CA	5/31-7/30/76
Blacksville, WV	6/23-7/31/76
"	8/1-8/30/76
Van Buren, AR	6/28-8/20/76
Brownsville, CA	7/26-8/20/76
Warrensburg, MO	7/15-8/13/76
Caves Juntions, OR	6/23-8/10/76
Faulkton, SD	7/12-8/21/76
Rainelle, WV	7/5-8/27/76
Independence, VA	7/7-8/21/76
Gunnison, CO (Shortage Area)	7/12-8/6/76
Stevenson, WA	8/1-30/76
"	6/1-7/2/76
"	7/5-8/13/76
Scott County, VA(Shortage Area)	6/19-8/14/76
Ringling,OK	6/21-7/16/76
Mellen, WI	6/28-7/30/76
Belle Glade, FL	6/14-8/13/76
Pagosa Springs, CO	5/3-7/30/76
Guerneville, CA	6/21-8/13/76
Downey, ID	7/5-8/13/76
Ilwaco, WA	8/16-9/30/76
Gaylord, MN	6/20-7/31/76
Liberty, IN	8/1-8/31/76
Moorefield, WV	6/28-8/20/76
St. Matthews, SC(Shortage Area)	6/19-8/14/76
"	6/19-8/14/76

SUMMER CYCLE - 1976 (Cont.)

NHSC Site Utilized	Dates of Student Placement
Bethel, AK (Shortage Area)	7/5-8/27/76
Deer Lodge, TN	6/19-8/14/76
Mound City, KS	7/15-8/27/76
"	6/1-7/30/76
Hiawassee/Blairsville, GA (Shortage Area)	6/19-8/14/76
Kayenta, Arizona	6/14-8/13/76
Fort Peck, NM	6/14-8/20/76
"	6/14-8/20/76
Wellsville, NY	7/15-9/1/76
Byrdstown, TN (Shortage Area)	6/19-8/14/76
New Canton, VA	8/9-9/30/76
Bracketville, TX	6/28-7/23/76
Plymouth, NC	5/31-7/30/76
Warner Robins, GA	7/12-8/6/76
Glenville, WV	5/24-7/16/76
"	7/26-8/20/76
Trinidad, CA	6/14-9/3/76
London Mills, IL	6/12-8/1/76
"	6/21-8/6/76
Owego, NY	7/1-8/15/76
Maxton, NC	6/21-7/30/76
Cherokee, AL	5/24-8/14/76
Superior, MT	5/24-7/30/76
Andover, NY	6/21-8/15/76
Matthews, MD	7/5-8/30/76
Harden, MT	7/19-8/27/76
Buffalo, WY	6/21-7/23/76
Onida, SD	6/14-7/23/76
Charlotte, MI	6/28-8/20/76
Yukon, WV	7/1-8/31/76
Etna, CA	7/19-8/27/76
Jasper, AR	6/14-8/23/76
Reisterstown, MD	7/5-8/13/76
Homedale, ID	9/6-9/30/76
Forks, WA	6/14-7/30/76
Vinal Haven, ME	9/6-9/30/76

AMERICAN MEDICAL STUDENT ASSOCIATION FOUNDATION
(Formerly Student American Medical Association Foundation)

AMSA FOUNDATION/NATIONAL HEALTH SERVICE CORP

PRIMARY CARE PRECEPTORSHIP PROGRAM

PROGRAM OVERVIEW AND EDUCATIONAL GUIDELINES

OVERVIEW

The AMSA Foundation views NHSC as a viable mechanism for the redistribution of health manpower to provider shortage areas in the United States. In order to be effective, however, the Corps must be able to interest/recruit young physicians before they have made career practice plans. In its experience since 1968 with health manpower programs, AMSA has found early exposure to medicine as practiced in shortage areas to be a key factor in influencing future health providers toward practice in those areas.

In placing medical and osteopathic students in preceptorship experiences on National Health Service Corps sites, the AMSA Foundation will be working toward the following goals:

1. To provide medical and osteopathic students experience in the delivery of primary care in a health manpower shortage area to:

   a. reinforce their interest in or attract them into primary care specialties;

   b. influence students related to their future practice location preference;

2. To involve the National Health Service Corps in the educational process of health science students;

3. To assist the NHSC assignees in establishing academic linkage and clinical backup for their practices;

4. To build up a resource of potential future health providers for the NHSC program.

The program will place 30 students, beginning with fall, 1976 and continuing through April 30, 1977, in a 6-12 week educational preceptorship in NHSC communities. The nature of the students' experience will vary, depending on priorities of each NHSC placement site, as well as the interest and capabilities of the student participant. It is the strong intent of the project, however, to introduce the student to the role of the NHSC and that of a primary care provider in a critical shortage area.

The student will be exposed to and become familiar with the health resources in the area and how they relate to the provision of health services in the community. He or she may help identify community health needs and assist in determining methods for their effective resolution within the context of potential community

resources. The student participants should be able to provide some acceptable service as a product of their learning experience. All clinical activity will be supervised by the licensed NHSC Preceptor.

Selection of NHSC communities and of students is based upon specific criteria which has been developed and information obtained from both sites and students. Tentative matching of preceptor and student is accomplished by the AMSA Foundation, with site needs and expectations correlated to student needs and expectations. After the tentative match, each preceptor and student applicant have an opportunity to concur prior to final placement. To the greatest degree practical, student participants are recruited from educational institutions in proximity to program sites in order to help develop a relationship between the institution and the particular NHSC community.

To ensure academic support for preceptor-preceptee teams and to develop further the school/site relationship, the AMSA Foundation will develop an educational support system. Within the proximity of NHSC preceptorship sites, the AMSA Foundation will attempt to identify a medical or osteopathic school interest in working with the project. An academic advisor from a primary care department (e.g., Family Practice, Community Medicine) will be identified; the primary function of this person will be to provide input from an educational perspective into the preceptorship experience. Specific responsibilities will include 1) recruiting students interested in primary care from that school into the project; 2) providing linkage between the project sites and the health science institution; 3) identifying and securing individuals from the academic community to assist in solving specific clinical and academic problems encountered by the preceptor-preceptee team in the field; 4) providing assistance in monitoring and evaluating the preceptorship experience, and advocating elective credit for the student.

Guidelines are provided for the preceptorship; these include overall goals and objectives, responsibilities of the preceptors and preceptees, description of the various support mechanisms available through the project, expectations for student involvement in various activities, suggestions for individual student projects, and a project evaluation plan. The AMSA Foundation provides student stipends, a living expense allotment and travel to and from the site. Each student participant will participate in a debriefing after the program has been completed.

The program will employ an evaluation protocol which assesses the educational value of the individual student's experience, the value of the overall program as a recruitment and service instrument for the NHSC, and the feasibility of the approach as a means to stimulate and sustain student interest in a primary care career field and practice in a shortage area. Both the NHSC preceptor and the student are expected to participate in the project evaluation.

PROGRAM OBJECTIVES

1. To introduce the student to the community and to the cultural, economic, political and environmental determinants of health in that community;

2. To acquaint students with the following aspects of medical practice;

   a. common problems that present to a primary care physician;

   b. the role of the primary care physician in the care of families, including

his relationships with consultants and community resources;

c. the four major phases of primary care: prevention and early diagnosis of a symptomatic disease, diagnosis and treatment of symptomatic disease and rehabilitation;

d. the physician's personal lifestyle, including his activities with his own family, in his hospital and local medical organizations, in his community, and in his own continuing medical education;

e. the management of a practice.

3. To provide students an opportunity to gain further clinical experience and skills in the primary care of families consistent with the student's level of training;

4. To allow students to become both medically and administratively familiar with the National Health Service Corps operation at his placement site and how it relates to the existing delivery system in the area;

5. To allow the student to become familiar with other parts of the regional health care system, i.e., public health, private practices, and other health projects;

6. To provide students with an understanding of the acute needs, challenges and career advantages for assuming a position with National Health Service Corps in a shortage area at some future date;

7. To provide students experience in identifying factors affecting health care with a family and community focus, and experience in defining treatment goals based on the patient's total situation;

8. To establish an educational support system in order to ensure adequate academic support to preceptor-preceptee teams and provide access to the regional medical schools for the NHSC assignees;

9. To monitor and evaluate the quality of the preceptorship in order to improve the learning experience for medical students.

RESPONSIBILITIES OF PRECEPTORS/STUDENTS

1. In conjunction with the student, the preceptor will set specific educational and service objectives for the preceptorship experience that will meet overall program objectives. The student will forward these objectives to the AMSA Foundation Office.

2. The student and preceptor periodically should review their activities in terms of the Educational and Service Objectives they have set.

3. The preceptor will arrange for the student's orientation to the community and will provide the initial entree to health facilities and other parts of the community health care system for the student. The student will be expected to take an initiative in following up on these contacts, in order to understand more fully the health delivery system.

4. The preceptor should prepare patients, office and hospital staff for an active role by the student in patient care.

5. As the range of the student's clinical abilities becomes known patients should be scheduled for the student to see in consultation with the physician. When practical, the student may take an initial history, perform an appropriate physical exam, discuss the patient's problems with the preceptor, and perform specific diagnostic and therapeutic procedures under direct supervision of the physician (e.g., well child care, assisting with surgery).

6. The preceptor should be available for teaching and to delegate responsibility to the student as appropriate, but avoid the use of the student's unsupervised service.

7. Both student and preceptor will participate in the project evaluation. In addition, the student will submit to AMSA a brief (2-5 pages) report of his activities, in terms of educational and service objectives, upon completion of the preceptorship.

SUGGESTED AREAS OF PROGRAM INVOLVEMENT

1. Clinical Involvement

The student should experience and observe the dynamics of patient care and management in an ambulatory primary care practice. The nature of involvement should be closely matched to the students' abilities and past responsibilities.

Suggested activities:

- histories
- physicals
- case discussions with preceptors
- dealing with various patient problems
    - . minor acute: trauma, lacerations, work related injuries, rashes and allergic reactions, otitis externa vs. otitis media, normal vs. pathologic throat
    - . chronic: hypertension, asthma, chronic bronchitis, pneumoconioses, dietary problems (obesity), diabetes, depression
    - . psychosocial: marital, sexual, alcohol abuse, vocational adjustment
- perfecting various skills
    - . lab: hematocrit, CBC, bacteriology (esp. throat cultures), blood drawing, x-rays, urinalysis
    - . theraputic: injections, sutur, IV's
    - . diagnostic: EKG's, x-rays, pelvic and rectal exams, differentiation of rashes, normal vs. abnormal ENT

- record keeping: problem oriented record, flow sheets, patient questionnaires

- doctor-patient relationships: dealing with a lonely hypochondriac, with a sick patient who is afraid to go to the hospital, with a chronically ill patient; evaluating problems through follow-up observations rather than lab tests

- experience with out-reach programs:

  - CB clinics
  - prenatal care
  - family planning
  - deliveries
  - well-baby clinics
  - medical assistance screening
  - pre-school physicals
  - sports physicals
  - house calls
  - nursing home calls
  - emergency room

- time with one or more of the following individuals to discover roles and problems:

  - RN
  - LPN or LVN
  - nurse clinician
  - nurse midwife
  - nurse anestetist
  - public health nurse
  - home health nurse or visiting nurse
  - medical technologist
  - x-ray technologist
  - physician's assistant
  - counselor
  - psychologist
  - emergency medical technologist
  - ambulance driver
  - paramedics of the fire department
  - social worker
  - physical or respiratory therapist
  - occupational therapist

- hospital rounds
- work with a private MD or at other nearby clinics
- mobile health van

Some Practical Questions in Clinical Involvement:

- Is the patient really sick? Does s/he require hospitalization or can the patient be managed at home? Can the patient afford the care you plan to give or even the tests you would automatically order if you were back at the medical center?

- Is the patient's problem beyond your expertise? Does the patient need a referral? If so, how do you decide where to send him/her? Will you

get the follow-up from the PMD to whom you refer? Will the patient go?

- Is the patient in need of medication? How do you decide which drug to give? Can the patient afford the drug? Will s/he take a pill four times a day, (i.e., what will be the compliance of that particular patient with that particular medication?) How do you keep track of how many pills a patient should have left, does have, asks for? How do you know what other drugs the patient has or is taking and for how long? What is that "little red and gray capsule" that they take when they are "feelin' poorly"?

- What medications, if any, are carried at your clinic? Are they obtained through retail men or wholesale houses? How is it decided which drugs to carry? Where is the least expensive place for the patient to get drugs -- your clinic, over the counter, or prescription? Does it depend on the type of insurance plan they have?

- Do you need a lab test on your patient? Can it be done in your clinic? Which tests are sent out? For which tests does the patient have to go to some other medical center? Can s/he afford to apy for the test? If travel is involved, can the patient provide his/her own? If not, can you obtain transportation?

- You want to see the patient again for follow-up. How do you decide how often you want to see that patient? Can s/he get to the clinic when you want him/her there? Is there a transportation problem? Are there organizations available to help transport patients to and from the clinic? How do you know if a patient doesn't come back? Is there any follow-up of those who don't?

2. Role of the Physician

In addition to increasing one's clinical skills, this experience offers an opportunity to observe, share, and help define the unique role of the primary care physician practicing in a shortage area.

Suggested Activities:

- Determine patient and community expectations of the physician patient education.

- Observe the relationship of the physician to the community in coordinating other medical and paramedical specialists for the benefit of the community, (e.g., training paramedical firemen, education of nurses to a new facility such as a neonatal intensive care unit), working with school and sports teams docs, developing sex education courses.

- Compare lifestyles and workstyles of all the physicians at the site:

  . social activities
  . educational opportunities
  . other methods of overcoming professional isolation
  . problems of maintaining an outside life (attitudes and strategies regarding off-duty hours, sharing call, emergency coverage, and getting away)

  - spouse's lifetsyle, how important is the spouse in defining the experience

- Evaluate primary care physician as an alternative to the university role models.

- Consider the advantages and problems of becoming a NHSC physician.

- Compare the Corps with other opportunities for young physicians.

3. Economic Determinants of Medical Care:

The student should become knowledgeable (identify in terms of importance and relationship) about the basic economic parameters which influence a primary care medical practice in a specified shortage area.

Suggested Activities:

- Board meetings

- Staff Meetings

- Billing and appointment system

- Medical records as economic necessity for third party payment and potential malpractice problems

- Advantages of single vs. group practices

- The practice- professional association, partnership, incorporated or what?

- Facility costs:

  - floor space
  - floor plan (traffic flow?)
  - equipment (office and medical)
  - cost to purchase
  - lease
  - build

- Service Costs:

  - salaries
  - supplies
  - facility
  - equipment
  - utilities
  - insurance
  - other

- Patient revenue:

  . number of patients per day
  . charges for services

- Spend time with some of the following in an effort to understand the interaction with support personnel and the utilization of other health professionals:

  . bookkeeper
  . receptionist
  . administrator
  . person who fills out third party insurance forms
  . hospital administrator
  . pharmacist
  . anesthetist
  . x-ray technician
  . medical technician
  . nurses
  . nurse-practictioner
  . nurse-midwife
  . physician's assistant
  . emergency medical technician
  . maintenance

Some practical questions in economics and business:

- Why did the clinic come about? Were there special needs? Whose idea was it and how did they get the money? How did it become a NHSC site? Are they paying the Corps back, are they progressing toward independence from NHSC monies; from parent organization monies?

- How are fees and method of payment determined? Do they charge for broken appointments? Is there a social service department at the clinic to aid with the financial and social problems? If not, is one easily accessible? Is there any attempt made to check whether certain procedures, lab tests, and medications are paying for themselves? In other words, are the charges for service economical yet reasonable?

- Why do patients choose your clinic as opposed to other health care? What kind of public relations was used to establish the clinic with the population?

- The property on which the clinic stands is being re-zoned in such a way that the present location will no longer be suitable for the practice - who decides where the clinic will re-locate?

- The practice is doing well and a sizeable profit will be incurred; who decides whether to invest the money and in what kind of investment, to reinvest in the practice by upgrading capital equipment or to disburse the funds as individual income to the members?

- Do physician extenders make practice more economical? Who hires and fires personnel and by what criteria? How many people do you need? Who decides on salaries, raises, benefits, and disciplinary actions

for support personnel? How do the staff interact among themselves and with patients?

4. Interaction with Other Parts of the Health System:

The student should gain a basic understanding of the various components comprising the health system (i.e., their function and relationship to each other).

Suggested Activities:

- Involvement with public sector:
  - public health
  - social service
  - welfare agancies
  - senior citizens groups
- Interaction with private medical sector
  - county and state medical societies
- Involvement with health planning agencies
- Interaction with local health activist groups
- Attendance at hospital staff meetings
- Acquiring knowledge of local transportation agencies for the elderly or handicapped

Some Practical Questions about the Health System:

- Is there a place for elderly people needing more care than the family is capable or willing to give? Are there places for the retarded, hopelessly ill or debilitated? Are there special schools for handicapped children and adults? Does the clinic have a well-oiled system of referrals to all of the places mentioned?
- Is there a local PSRO committee? Is it active? Effective? What is the attitude of the local physicians to peer review?

5. Community Involvement

The student should gain a basic understanding of the effects the sociology of a community has in determining the nature of the health system which services its needs.

Suggested Activities:

- Interaction with individual residents
- Interaction with civic organizations:

  - Rotary
  - Lions
  - Kiwanis
  - Chamber of Commerce

- Dinner with senior citizens groups

- Church sponsored activities

  - square dances
  - picnics
  - revivals

- School Board

- Women's auxillary meeting

- County fair

- Outdoor sporting activities

- Chicken roundups

- Knowledge of the geography, major industries and recreational facilities in the area

- Doctor recruitment committees

- Home visits with PHN or VNA

- Identifying one or two families and employing family oriented approach, determining the needs and doing appropriate followup

- Health center picnics and parties

6. Individual Student Service Projects:

The student will explore, in a task oriented way, a specific health related interest while meeting an identifiable community need.

Suggestions for Projects:

- Screening

  - hypertension
  - diabetes
  - glaucoma

- teaching

  - emergency medical technicians
  - community members

- patient education programs

- Utilization survey
- Fund raising project for the clinic
- Searching out "shut-ins" who are unable to get to the clinic

Criteria:

- Project must be based on an identifiable need (as determined by preceptor)
- Must be completable by the end of the preceptorship or conducive to followup by succeeding students or permanent personnel
- Must be commensurate with student's level of training and abilities
- Student and preceptor must be able to evaluate results of project with respect to service and educational value

CHARLES C. PAYTON, M.D.
President

PAUL R. WRIGI
Executive Direc

AMSA Foundation-NHSC Preceptorship Program:

Program Analysis and Evaluation Component

A. Assumptions Regarding the Functions of Program Evaluation and Analysis

In designing the procedures for evaluation and analysis of the preceptorship program it was assumed there would be two major users of the information provided: AMSA project staff who are responsible for implementation of the program; and the funding agencies, BHRD and NHSC. It was further assumed that AMSA project staff would want to use the information provided by program analysis and evaluation to assist them in improving the program in terms of goal attainment, i.e., to help them decide:

1. how to select preceptees in order to achieve given objectives;
2. how to design or modify program characteristics in order to achieve given objectives;
3. how to allocate their efforts, given that attainment of some goals are incompatible with others or that different goals are not equally feasible to attain.

It was assumed that the funding agencies would want to use the information provided by program analysis and evaluation to help them decide:

1. whether or not additional investment of resources in such preceptorship programs is justified by the effects achieved;
2. which future proposed preceptorship programs to fund, i.e., what the characteristics of such programs should be.

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For both sets of users of the results of program analysis and evaluation it was assumed there were multiple goals or objectives for the program and that these included influencing (in particular directions) the career dispositions, knowledge gain, physician role values, and concepts of NHSC of medical students.

B. Assumptions Regarding the Nature of Preceptorship Experiences and Their Effects

Prior experience in analysis of preceptorship programs strongly suggested that the content and form of NHSC preceptorships would be quite variable due to differences in preceptors, the nature of the medical service organization, the character of the surrounding community and patient population, the type of medical student and his/her degree of similarity to the preceptor, etc. A student's experience could range from those which were formally planned by his preceptor (e.g., doing physical exams), through those which might be expected to occur but were not formally planned (e.g., learning about local attitudes toward health care), to those which were unplanned and unanticipated (e.g., conflicts with clinic staff).

It was expected that the effects of these experiences would be as multi-faceted and variable as the experiences themselves. The knowledge gained about medicine, the NHSC as a delivery system, community agencies and power figures, co-professionals, patients, life in the "boondocks" (whether accurate or inaccurate) could affect, not only a student's career dispositions, but also his attitudes about physician roles and his subjective judgment of the value of the program. In addition, the impact of experience (and even the occurrence of experience) could be dependent upon certain attributes of the student himself, i.e., his personality, past experience, academic background, sex, age, etc.

C. The Extent of Data Collection

It is because of this assumed heterogeneity of experience and participants, the potential multiplicity of effects, and the desire for analysis to provide feedback for program modification that data collection is planned to be relatively extensive. It is to include indicators of several relatively "fixed" student attributes; measures of student career dispositions (and perhaps medical values) before and after participation in the preceptorship program; assessments of program characteristics (including preceptor characteristics) and activities; measures of perceived goal attainment along several dimensions by both preceptors and preceptees; preceptor judgments about student gain in knowledge and skills; and indicators of students' perceptions of NHSC.

More variables could be added although those envisioned seem to encompass the interests expressed in the contract. More adequate assessments of some variables could be developed (e.g., for student gain in knowledge and skill) and assessed before and after participation, but this might tend to exceed subject tolerances. Some variables could be deleted in the interests of brevity or because of lack of interest on the part of the users of the information provided by analysis and evaluation. Decisions between all of these options are mainly dependent upon practical considerations and the expressed needs of the users.

D. Design Considerations

The assumed functions of information from program analysis and evaluation imply two types of research design. The first type, which is of the group comparison variety, would allow one to make judgments about the value of the preceptorship program as a whole in yielding outcomes different from those which "ordinary" student experiences or maturation yield. The second type, of the within group or sub-group analysis variety, would allow one to make programmatic judgments

about how to optimize certain outcomes. Each type of design will be considered further below.

1. Group Comparision Designs

In the most basic experimental design an "experimental group" is exposed to an assumed causal (independent) variable while a "control group" is not. The two groups are then compared in terms of effects (dependent variables). Random assignment of members of a pool of subjects to experimental and control groups provides the basic safeguard against differences between the two groups that might lessen the validity of inferences about the effects of the experimental treatment. The chance assignment of subjects to the different conditions eliminates any systematic bias and guarantees the validity of the test of significance by which the results are judged.

In studies carried out in real-life settings, such as the present preceptorship program, compromises with the ideal of random assignment are usually necessitated by practical considerations. Individuals simply cannot be randomly assigned to a "preceptorship group" or a "non-preceptorship group" since it is a voluntary situation. Such "self-selection" almost certainly means that the groups being compared are not initially equivalent; they may differ in ways that strongly influence their positions on the dependent variables. There is really no way of getting around this problem in real-world research. However, the credibility of alternative hypotheses (i.e., alternative of the hypothesis that the treatment causes the observed effect) can be reduced by certain kinds of procedures.

One set of procedures attempts to check on or present evidence for the initial comparability of the experimental and comparison groups. The "before-after" measurement of positions on the dependent variable is the most familiar example although this is only a partial substitute for random assignment since

the possibility remains that the two groups may differ in other characteristics that may interact with the experimental variable to lead to final differences on the dependent variable. Case by case matching of individuals on variables assumed to be relevant is another method to insure comparability of groups. However, the greater the number of factors on which matching is to take place, the greater the number of cases for which no match will be possible so that huge numbers would be necessary to begin with. Frequency distribution control is a less costly type of matching where experimental and control groups are either shown to have (or made to have) similar over-all distributions on given factors. It has the potential disadvantage that the groups may be badly mismatched on combinations of factors. Whichever method or combination of methods is used, one cannot assume that because one has not conclusively demonstrated things to be unequal, one has demonstrated them to be equal.

Another set of procedures attempts to achieve comparability of groups in the data analysis stage of investigation. Examples are: comparison of matched subgroups within each group; restricting the samples to only persons with certain characteristics; achieving statistical control through analysis of covariance and partial correlation procedures.

Since none of these substitutes for experimental procedures provides as much protection as does randomization, it is advisable to plan as many different approaches as possible to provide a basis for making inferences about causality. Thus, in the event that comparisons of NHSC preceptorship students and other groups of medical students are made, it is proposed that:

a) there be matching of groups on certain "critical" variables such as personality type, age, and stage in medical school, sex, etc. The kind of matching which is possible and the specifics to be matched must await development of some notion of what is important (see below)

b) any observed lack of matching between groups be controlled statistically, if possible

c) the design be a before-after study with three comparison groups. This design has been suggested to provide safeguards when contemporaneous events or developmental changes may be expected to influence the results. In this design the groups to be compared are:

Treatment group: pre measurement - treatment - post measurement
Comparison group I: pre measurement - no treatment - post measurement
Comparison group II: no pre measurement - treatment - post measurement
Comparison group III: no pre measurement - no treatment - post measurement

In this design, the difference between the post-measure for comparison group III and the average of the combined pre-measure scores of the treatment group and comparison group I are taken to represent the effects of contemporaneous events or of developmental processes since neither the pre-measure nor the treatment was present in this group. The change in comparison group II represents the effects of the treatment variable and of contemporaneous events or developmental processes; changes in comparison group I the effects of the pre-measurement and of contemporaneous events or developmental processes. The effect of the treatment alone can be determined by subtracting the "change" in comparison group III from the change in comparison group II; the extent to which the change in the treatment group reflects the effects of the pre-measure, the experimental variable, of uncontrolled events or of interaction between the factors can be determined by comparison of the change in this group with those in the other groups.

Because information about what kinds of students self-select into the NHSC preceptorship program is needed in order to find appropriate comparison groups, it is proposed that this phase of the project not be implemented at this time. Another consideration has to do with the degree of optimization of the preceptorships at this stage in the project. That is, it is possible that feedback of program analysis information (from the type of analysis described below) into the operation of the preceptorships could lead to greater effects than would be observed in earlier stages of the program. If the project were terminated on

the basis of comparisons at the early stages one would never know that it could become effective.

2. Within Group Analysis

Classical experimental designs (and quasi-experimental designs) have been criticized for artificially linking or unlinking variables in a manner that is not representative of the way they exist in nature, i.e., that they throw the picture of the interplay of factors out of balance and lead to misinterpretations and faulty overgeneralizations. For the feedback functions of program analysis information this could be disasterous.

The alternative approach proposed is to investigate variables in the context of the naturally occurring concomitant variation of other factors (i.e., to take the interplay among variables as it is found in the situations in the sample), measure as many relevant factors as possible, and use statistical techniques to ferret out relationships. In other words, this type of design disregards the notion of control or comparison groups and extracts information solely from the "natural" variation and covariation of independent and dependent variables.

The kinds of multivariate statistical designs are legion and cannot be considered here in any depth. However, an example will be presented to illustrate the kind of information which can be provided for program feedback.

Multiple regression is a technique which produces a linear combination of independent variables which are weighted so as to maximize the correlation with a dependent variable while taking into account the inter-correlations among the independent variables. When all the variables are normalized, the magnitude of the weights assigned to the independent variables in the prediction equation reflect the strength and direction of the direct relationship between independent and dependent variables.

Multiple regression can be used in the analysis of data from the NHSC preceptorship program in order to ascertain the relative contributions of each of the measured program characteristics and student characteristics to: the gain in certain kinds of knowledge or skill by preceptees; the gain (or loss) in inclination toward NHSC; the disposition toward primary care areas of medicine subsequent to the preceptorship; disposition toward practice in rural areas, etc. This information can be fed back to those responsible for implementing the project to assist in making decisions about how best to implement program objectives. For example, the results could indicate which of a large number of variables that it is possible to manipulate would lead to the greatest payoff in terms of some objective. Or, the results could indicate how certain tactics might implement one objective but detract from the attainment of others. In the latter case the program administrators would either have to abandon the particular variable or variables as ones to manipulate or they would have to establish priorities among objectives.

E. A Framework for Considering the Problem

There are a number of questions, of varying scope and qualification, that can be asked about the NHSC preceptorship program. For example, one might want to know what the overall (main) effect of some personality characteristic is on disposition toward working for NHSC; or one might want to know how this effect is dependent upon the personality type of the preceptor or upon the amount of time spent in direct patient contact. One might also want to know how much the frequency of certain student activities during the preceptorships are dependent upon the student's initial career dispositions and physician role values. Similarly, questions can be phrased in different ways and the particular phraseology will determine what is the appropriate analytic technique.

The data set proposed for the AMSA-NHSC Preceptorship Program is broad enough and flexible enough that a wide variety of questions can be asked of it and a number of analytic techniques applied - even though these are not completely anticipated at the outset. It is based on the assumption that there are three major domains of variables: student input variables, program characteristics, and outcome variables.

Student input variables are all those things the preceptee "brings with him" to the preceptorship experience. Although they are all basically "mental" variables (motivations, cognitive styles, abilities, attitudes, etc.), they are often indexed indirectly by background variables, past experience, etc.

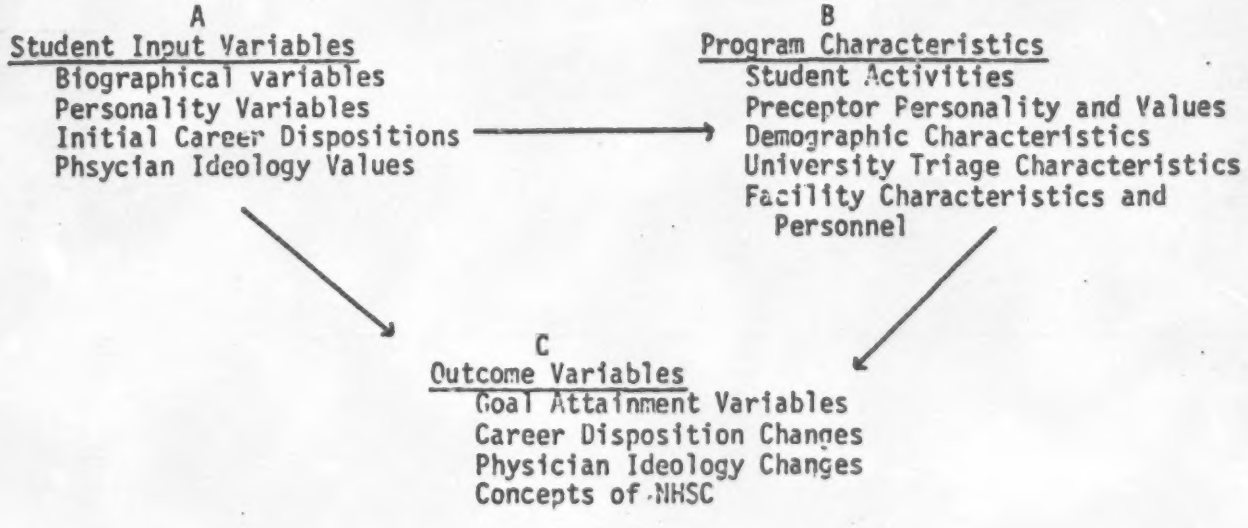
Program characteristics are those variables descriptive of the experience and activities of the preceptee as well as the context of the preceptorship. Included in this domain are such things as frequencies of assorted clinical activities, preceptor characteristics, community characteristics, nature of the university linkage, involvement in community affairs, degree of exposure to the business aspects of medical practice, character of the clinical organization, etc.

Outcome variables are, of course, the dependent variables of interest: changes in career dispositions, concepts of NHSC, goal attainment by preceptor and preceptee, etc.

The presumed causal relations among the three domains are shown in the accompanying diagram. Student characteristics are considered to be able to influence at least some program characteristics (e.g. frequency of certain activities) as well as outcome variables. Program characteristics are considered capable of affecting outcome variables but not student input variables. The relationships of variables within domains are not specified.

The magnitude of variables in the student input domain are assumed to be at least partially responsive to preceptee selection procedures, types of promotional-recruitment campaigns, and the like. Some program characteristics are assumed to be responsive to instruction, preceptor selection, site selection, etc. Outcome variables are controllable by controlling student input variables and program characteristics. Since some of the variables in these two previous domains are essentially uncontrollable, it follows that outcomes will always retain some degree of variability.

The set of relationships among variable domains provides a framework for considering possible within-group analysis. Thus, if interest were restricted to consideration of how student characteristics affect the nature of the preceptorship program, one could analyze the A-B relationships. Similarly, if one were concerned only about the affects of program characteristics upon outcomes, one could focus analyses on the B-C linkages. If one were interested in the interaction of program characteristics and student input variables in determining outcomes, one could analyze the B-C linkages for different subgroups of A. If one wanted to view the interrelationships of variables in all three domains all at once, one could construct a path analytic causal model.



F. Phases in Program Analysis and Evaluation

Because of budgetary limitations, the need for certain kinds of information, and the initially small number of subjects, it is impossible to carry out all of the procedures outlined above during the first year of the project. It is therefore proposed that this aspect of the project be conducted in phases over a period of years.

Phase I: Establish data elements to be collected on project participants; pilot test instruments; initial within group analyses; feedback to project staff.

Phase II: Revise instruments if necessary; conduct more complex within group analyses on larger N; feedback.

Phase III: Add comparison groups and do between group analyses; complete within group analyses.

*
Myers-Briggs Type Indicator-Form F

* This answer coding sheet has been removed because of copyright restrictions.

Name _____

School _____
Site where participating _____

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1 2 3 4 5 6 7

BIOGRAPHICAL QUESTIONNAIRE

card 3

1. *Age*
08,09 _____

2. *Sex*
10-1 _____M 10-2 _____F

3. *Marital Status*
11-1 _____Married 11-2 _____Single 11-3 _____Other (specify) _____

4. *Religion*
12-1 _____Protestant 12-2 _____Catholic 12-3 _____Jewish 12-4 _____Other 12-5 _____No affiliation

5. *Racial Background*
13-1 _____Black 13-2 _____American Indian 13-3 _____Caucasian 13-4 _____Oriental
13-5 _____Mexican, Spanish American, Chicano 13-6 _____Puerto Rican 13-7 _____Other

6. *Parents Discipline/Occupation*

	Father	*Mother*
Medicine	14,15-1 _____	16,17-1 _____
Pharmacy	14,15-2 _____	16,17-2 _____
Osteopathy	14,15-3 _____	16,17-3 _____
Dentistry	14,15-4 _____	16,17-4 _____
Veterinary Medicine	14,15-5 _____	16,17-5 _____
Optometry	14,15-6 _____	16,17-6 _____
Podiatry	14,15-7 _____	16,17-7 _____
Nursing	14,15-8 _____	16,17-8 _____
Other health profession	14,15-9 _____	16,17-9 _____
Other health worker	14,15-10 _____	16,17-10 _____
Non-health profession	14,15-11 _____	16,17-11 _____
Owner, manager, administrator (non-farm)	14,15-12 _____	16,17-12 _____
Clerical or sales worker	14,15-13 _____	16,17-13 _____
Transporter or equipment operator	14,15-14 _____	16,17-14 _____
Craftsman or skilled worker	14,15-15 _____	16,17-15 _____
Unskilled worker, laborer, private household worker (non-farm)	14,15-16 _____	16,17-16 _____
Farmer, farm manager	14,15-17 _____	16,17-17 _____
Farm foreman, farm laborer	14,15-18 _____	16,17-18 _____
Homemaker	14,15-19 _____	16,17-19 _____
Other	14,15-20 _____	16,17-20 _____

7. *Community Where You Spent Your High School Years*
18-1 _____Large metropolitan area (500,000 people or more)
18-2 _____Suburb of large metropolitan area
18-3 _____Smaller metropolitan area (100,000 to 500,000 people)
18-4 _____Suburb of small metropolitan area
18-5 _____Medium sized city (25,000 to 99,000)
18-6 _____Small town (1,000 to 24,999)
18-7 _____Rural area, farm, reservation, town of less than 1,000)

8. State (or foreign country) where you spent most of your high school years. _____
(Do not write in this space
19,20 _____)

9. Number of children in your family including yourself.
21,22 _____.

10. *Undergraduate Major*

23-1 ____Biological Sciences	23-6 ____Education
23-2 ____Physical Sciences	23-7 ____Engineering
23-3 ____Social Sciences	23-8 ____Business
23-4 ____Humanities	23-9 ____Economics
23-5 ____Fine Arts, Architecture	23-10 ____Health Professions (e.g. nursing)

11. Please indicate whether you have had or have not had occupational or organizational experience in the following areas prior to entry into medical school:

	HAD EXPERIENCE	NO EXPERIENCE
Experience in medical care setting, e.g., working in a hospital, ambulance attendant, work in clinical laboratory (but *not* a research lab), etc.	24-1 _____	24-2 _____
Experience in "helping" activities, e.g., counselor, playground director, social casework, work with underprivileged children or adults, work with juvenile corrections, Peace Corps, VISTA, etc.	25-1 _____	25-2 _____
Research or Technical experience, e.g., lab technician, biologist, engineer technical aide, research assistant, etc.	26-1 _____	26-2 _____
Teaching experience, e.g., instructor, tutor, graduate assistant, etc.	27-1 _____	27-2 _____
Experience in dealing with the public, e.g., salesman, public affairs officer, etc.	28-1 _____	28-2 _____

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Name _____

School _____
Site Where
Participating _____

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___ ___ ___ ___ ___ ___ ___
1 2 3 4 5 6 7

CAREER RATING AND PREFERENCE QUESTIONNAIRE

card 1

08,09 At this point in your professional development, in what area or specialty of medicine do you plan to work?_____

___ _____

1. Please rate all of the following areas of medicine in terms of your current inclination or disinclination to practice in them. (Mark the number indicating your opinion in the space provided before the titles.) PLEASE USE THE FOLLOWING SCALE:

1 = Strongly inclined to *avoid*
2 = Moderately inclined to *avoid*
3 = Slightly inclined to *avoid*
4 = Neither inclined nor disinclined
5 = Slightly inclined to *select*
6 = Moderately inclined to *select*
7 = Strongly inclined to *select*

10 ____Allergy
11 ____Anesthesiology
12 ____Basic Medical Science
(e.g., Pharmacology, Physiology)
13 ____Cardiology
14 ____Dermatology
15 ____Emergency Medicine
16 ____Endocrinology
17 ____Family Medicine
18 ____Gastroenterology
19 ____General Practice
20 ____General Surgery
21 ____Geriatrics
22 ____Internal Medicine
23 ____Neurology
24 ____Neurosurgery
25 ____Obstetrics-Gynecology
26 ____Opthalmology
27 ____Orthopedics
28 ____Otolaryngology
29 ____Pathology
30 ____Pediatrics
31 ____Physical Medicine and Rehabilitation
32 ____Plastic Surgery
33 ____Psychiatry
34 ____Pulmonary Diseases
35 ____Public Health/Preventive Medicine
36 ____Radiology
37 ____Thoracic Surgery
38 ____Urology

2. Please rate each of the following career settings in terms of your current inclination or disinclination to work in them. PLEASE USE SCALE ABOVE IN #1).

39 ____Private Practice, solo
40 ____Partnership
41 ____Private Practice, Groups:
42 ____Mixed Specialty (e.g. small clinic)
43 ____Team Practice of one specialty
44 ____Large Group (hospital based)
45 ____Government Institutions or Agencies
46 ____VA Hospital
47 ____Military Hospital
48 ____City, State or County Hospital
49 ____City, State, or County Health Department
50 ____Public Health Service (non-hospital based)
51 ____Government Sponsored Health Program
52 ____National Health Service Corps
53 ____Non-government Institutions or Agencies
54 ____Industry
55 ____Private Hospital (staff physician)
56 ____Independent Medical Foundation (e.g. Kaiser Foundation)
57 ____Research Facility (medical school or any of above)
58 ____Educational Institution (e.g. medical school)

3. Assuming a position you obtained allowed for a variety of professional activities, what percentage of your time would you like to devote to (sum of responses should total 100%):

59,60 ____Direct Patient Care
61,62 ____Teaching Medical Personnel
63,64 ____General Administration
65,66 ____Program Planning and Development
67,68 ____Case Consultation
69,70 ____Professional community service (talks, advisory groups)
71,72 ____Supervision of others
73,74 ____Research
75,76 ____Other you would include (please specify):

_____

4. How important do you think each of the following categories of community and work setting characteristics will be in your choice of a position or practice setting after completion of your medical training? Please rate each characteristic on a seven-point scale where 1 = not at all important—will not consider, and 7 = extremely important—crucial to any decision; the integers in between represent gradations of importance between these two extremes.

card 2

OPPORTUNITIES FOR:

8 ____Geographical location
9 ____Size (population)
10 ____Community Economic Status
11 ____Quality of Public School System
12 ____Age Distribution of Population
13 ____Ethnic Distribution of Population
14 ____Political "climate"
15 ____"Pace of Life"
16 ____Distance from a Metropolitan Area
17 ____Distance from a Medical School
18 ____Availability of Support Services (e.g., labs)
19 ____Income/Salary
20 ____Ability to Control Income (e.g., set fees)
21 ____Job Security, Benefits
22 ____Type of Patients or Clients
23 ____Variety of Practice Activities
24 ____Ability to Control Hours
25 ____Ability to Control Patient Load
26 ____Frequency of Need to Meet Emergencies
27 ____Amount of "red tape" involved in carrying out job activities
28 ____Prestige of Organization or Group
29 ____Professional Abilities of Co-workers
30 ____Personal Characteristics of Co-workers
31 ____Amount of Routine Task Activity
32 ____Your preferred cultural, recreational or entertainment activities
33 ____Working in your most preferred type of work setting (please see list, Question #3)
34 ____Your spouse to obtain employment or pursue a career
35 ____Being in a high demand/low supply specialty for the area
36 ____Proximity to persons prominent in your field of medicine
37 ____Part-time affiliation with a Medical School
38 ____"Getting Ahead" Professionally
39 ____Directing others in their work
40 ____Molding one's own roles, duties and activities
41 ____Trying out one's own ideas
42 ____Expanding one's own knowledge in an area of medicine
43 ____Working with other physicians on some joint task
44 ____Working with non-physicians in a Treatment Team
45 ____Other Characteristics (please specify):

_____

5. When you have completed your medical education, would you prefer or not prefer to work in a community with the following characteristics? Please rate each characteristic on a seven-point scale where 1 = strongly inclined to *avoid*, and 7 = strongly inclined to *prefer*.

Location:

46 ____Northeastern United States
47 ____Southeastern United States
48 ____Midwest
49 ____South Central (TX, AR, OK)
50 ____Rocky Mountain States
51 ____West Coast
52 ____Other (please specify): _____

Size of Community:

53 ____Over 100,000 Population (large metropolitan area)
54 ____Suburban Area Adjacent to Large Metropolitan Area
55 ____Population between 50,000 and 100,000 (medium city)
56 ____Population between 10,000 and 49,999 (small city)
57 ____Population less than 10,000 (small town or rural)

Economic Status of Community:

58 ____Poverty Area or Low Economic Status
59 ____Moderate or Mixed Income Area
60 ____Wealthy Community

Typical Life Style or "Pace"

61 ____Community with a "Fast" pace (e.g., New York, Los Angeles, Chicago)
62 ____Community with a "Moderate" pace of life (e.g., Albuquerque, Tucson)
63 ____Community with a "Slow" pace (e.g., Hitching Post, Kansas; Wagon Mound, New Mexico)

Please use the scale below to rate the following items:

1 = Strongly inclined to *avoid*
2 = Moderately inclined to *avoid*
3 = Slightly inclined to *avoid*
4 = Neither inclined or disinclined
5 = Slightly inclined to *select*
6 = Moderately inclined to *select*
7 = Strongly inclined to *select*

6. How inclined would you be to work with the following types of individuals in practicing medicine?

64 ____Nurse Practitioner
65 ____Physician's Assistant
66 ____Physical Therapist
67 ____Laboratory Technician
68 ____Nurse-Midwife
69 ____Health Administrative Staff
70 ____Community Health Worker
71 ____Visiting Nurse
72 ____Licensed Practical Nurse
73 ____Rehabilitation Therapist
74 ____Public Health Nurse

7. How inclined would you be to work as a member of the following kinds of health teams?

75 ____A team where the physician is in authority with several allied health personnel working directly under his supervision.
76 ____A team where each member is given authority to make patient care decisions in his own area of expertise without physician approval.
77 ____A team which functioned under the administration of a citizen's board with physicians and other medical personnel responsible for policy decisions affecting health care deliver'.
78 ____A team which functioned under the supervision of a citizen's board with citizens having major input into policy decisions affecting health care delivery.

8. At the point when you are ready to enter practice, would you be interested in having the opportunity to make contact with others who have similar practice interests?

79-1 ____Yes 79-2 ____No

At the point when you are ready to enter practice, would you be interested in obtaining detailed information about existing innovative team/group practice models which have proved successful?

80-1 ____Yes 80-2 ____No

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Name _____

School _____

Site where participating _____

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1 2 3 4 5 6 7

POST-PRECEPTORSHIP ASSESSMENT

(Preceptee form)

1. The purpose of this questionnaire is to determine the extent to which a variety of experiences are available at different preceptorship sites. On the basis of *your experience* at this site, please indicate how frequently you engaged in each of the following activities, using the rating scale provided below:

1 = Never
2 = Once or twice
3 = Several times (3 or 4)
4 = About once a week
5 = Several times a week
6 = Once a day
7 = More than once a day

card 6

08 ____Took patient histories
09 ____Performed physical examinations
10 ____Performed diagnostic procedures (e.g., lab tests)
11 ____Performed therapeutic procedures (e.g., suturing)
12 ____Made hospital rounds
13 ____Filled out patient medical records
14 ____Attended continuing education activities
15 ____Discussed diagnosis and treatment plans with patients
16 ____Consulted with private community physicians or other community health personnel about patients
17 ____Participated in preventive health programs (e.g., immunizations)
18 ____Worked in an emergency room
19 ____Developed and/or monitored rehabilitation plans
20 ____Discussed and/or set medical fees with patients
21 ____Developed treatment goals and methods of attainment
22 ____Used medical journals or books as a resource for diagnosis and treatment
23 ____Consulted with medical school physicians about certain patients
24 ____Participated in a "team approach" to medical care (i.e., a group of health professionals who together develop and monitor treatment plans)
25 ____Attempted to involve the family of an identified patient in improving family health care
26 ____Filled out insurance and other third party payment forms
27 ____Scheduled and monitored patient follow-up
28 ____Provided health education information to patients (e.g., nutrition, preventive care, etc.)
29 ____Ordered equipment or supplies for the site
30 ____Examined office records (e.g., collections, expenditures)
31 ____Attended meetings of local medical organizations
32 ____Discussed community health needs/goals with local community

2. How frequently did you work or consult with each of the following kinds of health professionals or institutions/agencies? (USE SCALE ABOVE IN #1)

33 ____Nurse Practitioner
34 ____Physician's Assistant
35 ____Physical Therapist
36 ____Laboratory Technician
37 ____Nurse-midwife
38 ____Visiting Nurse
39 ____Licensed Practical Nurse
40 ____Registered Nurse
41 ____Rehabilitation Therapist
42 ____Public Health Nurse
43 ____Mental Health Worker
44 ____Community Health Worker
45 ____Private Physicians
46 ____Health Administrative Staff
47 ____Public Health Clinic
48 ____Community Mental Health Center
49 ____Old Age Facility
50 ____Welfare/Social Service Department
51 ____Private Hospital
52 ____Medical School

3. How frequently did you engage in the following non-medical activities (USE SAME SCALE AS #1)

53 ____Church activities
54 ____Community socials
55 ____Outdoor sports/activities
56 ____Cultural activities
57 ____Informal social activities with members of site staff
58 ____Informal social activities with individuals in community

4. During the time you spent at the site, did you become interested in . / social/recreational activities which were new to you?

59-1 ____Yes 59-2 ____No If yes, please describe _____

5. On the average what percentage of your working time was devoted to each of the following activities: (sum of responses should total 100%)

60,61 ____Direct patient care

62,63 ____Administrative activities

64,65 ____Program planning and deve'opment

66,67 ____Case consultation

68,69 ____Community service

70,71 ____Other (specify) _____

6. In general, how would you rate this community in terms of its attractiveness with respect to the following (use scale below):

1 = Very unattractive
2 = Moderately unattractive
3 = Slightly unattractive
4 = Neither attractive nor unattractive
5 = Slightly attractive
6 = Moderately attractive
7 = Very attractive

72 ____A place to practice medicine for a few years

73 ____A place to set up long-term medical practice

74 ____A place for a single physician

75 ____A place for a married physician

76 ____A place to bring up a family

77 ____A place to practice medicine as a private physician

78 ____A place to practice medicine as an NHSC physician

7. To what extent did your preceptorship experience increase your awareness, understanding or knowledge of each of the following? Use a seven point rating scale where 1 = not at all, to no extent, and 7 = a great deal, to a great extent. The integers in between represent gradations between these two extremes.

card 7

08 ____Methods for managing epidemic disease

09 ____The available mechanisms for financing health care

10 ____Methods of improving community health status

11 ____How to contribute my own skill and knowledge to the functioning of a health team

12 ____How to use other resources for health care available in the community

13 ____The special health care needs of the elderly

14 ____Methods of disseminating important health information to the community at large

15 ____How to seek out medical consultation from less readily available sources outside the community

16 ____How patients enter and move through the system of medical care in the community

17 ____How to work with community health agencies in the management of particular patients

18 ____Typical consumer resistances to different forms of health care delivery (e.g., large hospital based)

19 ____Typical consumer resistances to "modern" health care procedures (e.g., lab technicians, physician extendors)

20 ____The special skills and capabilities of physician extendors

21 ____How to work effectively with poorly educated or poorly motivated patients

22 ____How to develop treatment strategies suited to the values and needs of particular ethnic and socio-economic groups

23 ____How to "diagnose" environmental and/or social contributors to illness

24 ____How to work on health problems at a community program level

25 ____What factors are important in making an office practice economically viable

26 ____How to use and maintain office medical equipment

27 ____How to deal with medical emergencies

28 ____How to select appropriate methods for augmenting my clinical knowledge

29 ____When to admit patients to the hospital

30 ____How to use problem-oriented medical records

31 ____How to establish treatment goals in the context of the family and psycho-social situation of the patient

32 ____How to admit patients to the hospital

33 ____How the various elements of a hospital function separately and together

34 ____The special features of managing chronic illness

35 ____How to work effectively with the facility's governing community board

36 ____My own strengths and weaknesses in the area of patient interaction

37 ____My own strengths and weaknesses in interacting with other health professionals

8. To what extent did your experience help in clarifying your own preferences in each of the following areas? (Use scale above where 1 = not at all, to no extent, and 7 = a great deal, to a great extent.)

38 _____Area of medicine (specialty)
39 _____Type of practice (e.g., solo, group)
40 _____Type of work (e.g., clinical, administration, teaching)
41 _____Geographic region of practice
42 _____Size of community in which to locate
43 _____Desired socio-economic characteristics of patient population
44 _____Work in the private vs. the government sector

9. To what extent do you think your presence at the site (use scale above in 7 & 8):

45 _____Increased the daily work load of the preceptor
46 _____Decreased the daily work load of the preceptor
47 _____Increased the work load of other staff members
48 _____Decreased the work load of other staff members
49 _____Added to community awareness, knowledge or effectiveness with regard to community health problems
50 _____Improved health care attitudes and behaviors of individual patients
51 _____Increased community understanding/acceptance of the NHSC preceptorship project
52 _____Facilitated utilization of medical school faculty consultation on clinical problems
53 _____Provided community members with a better understanding of the needs and interests of young physicians
54 _____Provided intellectual stimulation for the preceptor
55 _____Added to the effectiveness of clinic operations

10. To what extent were you *satisfied* with your preceptor with regard to each of the following? (Use same scale where 1 = to no extent, not at all satisfied, and 7 = to a great extent, extremely well satisfied.)

56 _____Allowing me freedom to explore my own interests in medicine
57 _____Providing constructive criticism of my clinical skills
58 _____Providing constructive criticism of my patient-interaction skills
59 _____Instructing me in the economics of office practice
60 _____Legitimizing my presence and activities in community health care facilities
61 _____Matching his/her level of expectation with my level of training
62 _____Including me in social/recreational activities
63 _____Including me in all aspects of his/her work
64 _____Appropriately guiding the work on my project
65 _____Instructing me in the use of community medical and social service consultative resources
66 _____Being available when I needed him/her
67 _____Being willing to allow me to undertake tasks of which I felt I was capable
68 _____As a preceptor, in general

11. To what extent were each of the following phenomena *characteristic* of your preceptorship experience? (Use scale where 1 = to no extent, extremely uncharacteristic, and 7 = to a great extent, extremely characteristic.)

69 _____High quality medical care was provided at the site
70 _____The preceptor varied his approach to patients who possessed different values and expectations
71 _____The preceptor provided "on the spot" coaching and criticism of my performance
72 _____The preceptor and I met to discuss patients
73 _____The preceptor and I reviewed and evaluated my learning experience at the site
74 _____There was disagreement among the staff concerning staff responsibilities
75 _____Interpersonal relations among site staff were harmonious
76 _____Role confusion was evident among various site staff members
77 _____Difficult or unusual cases were referred out to other physicians or facilities
78 _____The preceptor and I had informal discussions about various aspects of being a physician
79 _____I felt uncomfortable or confused about my role and duties at the site
80 _____The physicians at the site had different approaches to patient care

card 8

08 _____I felt I was making a unique contribution to the health care team
09 _____The preceptor made me feel ignorant or inadequate
10 _____The preceptor complimented me when I did an outstanding job
11 _____The preceptor "stood over my shoulder" when I was doing things
12 _____I disapproved of the way the preceptor behaved toward certain patients

12. Based upon your knowledge and experience of the NHSC, please rate the following in terms of the *extent to which* you judge they would be *characteristic* of working as a NHSC physician. (Use same scale where 1 = to no extent, extremely uncharacteristic, and 7 = to a great extent, extremely characteristic.)

13 _____Having responsibility for defining one's role, duties and activities
14 _____Having personal control of amount of time devoted to patient care
15 _____Being able to try out new ideas
16 _____Sharing patient responsibility with other physicians
17 _____Maintaining a fairly consistent and predictable patient-scheduling system

12. (Continued). (Use same scale where 1 = to no extent, extremely uncharacteristic, and 7 = to a great extent, extremely characteristic.)

18 _____Dealing with emergency medical problems
19 _____Having sufficient opportunity for professional advancement
20 _____Obtaining intellectual stimulation through interaction with colleagues
21 _____Performing habitual or nonvarying medical activities
22 _____Having satisfactory coverage for patients during periods of absence
23 _____Having the opportunity for appreciation and prestige from the lay public
24 _____Having accessible consultation services
25 _____Being isolated from other physicians
26 _____Working with or under a community board or citizens' group
27 _____Taking less vacation and/or free time than one is entitled to take
28 _____Maintaining one's preferred "pace of life"
29 _____Determining the amount of free time and/or vacation time
30 _____Receiving an income adequate to fulfill the needs of one's "life style"
31 _____Being burdened with excessive "red tape" in providing adequate medical care
32 _____Having personal control over the progress of one's medical career

13. Please indicate the extent to which you agree with each of the following statements using the scale below:

1 = Strongly disagree
2 = Moderately disagree
3 = Slightly disagree
4 = Neither agree nor disagree
5 = Slightly agree
6 = Moderately agree
7 = Strongly agree

33 _____The family physician has unique skills and functions which can't be duplicated by medical specialists or physician extendors
34 _____Providing total medical care in the context of a patient's family is a good idea, but it doesn't work out well in practice
35 _____In light of uncertainties about the future forms of health care delivery, a salaried position in a government sponsored delivery system is very attractive
36 _____Government involvement in health care delivery is bound to create more problems than it solves
37 _____The primary care physician is likely to feel that the care he provides is second-rate
38 _____Top-notch modern medicine simply can't be practiced in remote areas given the lack of support facilities and expert consultation
39 _____The satisfaction of knowing you have provided medical care where little or none existed before, is sufficient motivation for practicing in a remote shortage area
40 _____The demands on the time of a primary care physician in a remote setting make it impossible for him/her to have a satisfying personal life
41 _____With medical specialists above him and physician extendors below, not much of an area of expertise is left for the family physician
42 _____Isolation from the larger medical community is an important deterrant from practicing in a remote area
43 _____Patients are likely to be suspicious of physicians who work for the federal government
44 _____The lack of intellectual and social stimulation in small communities outweighs the appeal of the slower-paced life style
45 _____Salaries for NHSC physicians will have to be quite a bit higher to attract physicians to the corps
46 _____A physician who likes to feel he's/she's his/her own boss is likely to be dissatisfied working with NHSC
47 _____There is little difference between working as a private physician in a shortage area versus working as an NHSC physician in the same place
48 _____A few years with the NHSC is a good way for a young physician to make up his mind about his/her future career goals
49 _____Providing primary care in the absence of all the trappings of modern medicine is exciting and a challenge to the skill and ingenuity of the physician
50 _____A responsible primary care physician in a remote area will always send his/her more difficult cases to specialists
51 _____Seeing the results of your treatment is perhaps the most gratifying aspect of providing primary medical care
52 _____The challenge of being in a position to improve both individual as well as environmental health in a small community, is very appealing
53 _____Most of the medical problems seen by primary care physicians in small communities are routine and uninteresting
54 _____The expectations community members have of a local doctor are unrealistic and cannot be fulfilled by a family physician
55 _____You don't need a high-powered medical school education to adequately treat the majority of problems brought to the primary care physician
56 _____Outside of work, there isn't much to do in the boondocks

14. General Information

57 _____Present year in medical school
58,59 _____Length of preceptorship (weeks)
60,61 _____Average number of hours spent per day at medical facility
62 _____Number of nights per week you were "on call"
63,64,65 _____Average number of patients per day treated at facility

Have you been a preceptee in this program before?

66-1 _____No 66-2 _____If *Yes*, when and where? _____

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Name _____ 1 2 3 4 5 6 7

Site where participating _____ 8 9 10

NHSC PRECEPTOR WORK-SETTING ASSESSMENT

1. **On the average, what percentage of your time is devoted to each of the following activities (Sum of responses should be 100%):**

card 10

11,12 ____ Direct patient care

13,14 ____ Teaching or supervision

15,16 ____ General administration

17,18 ____ Program planning and development

19,20 ____ Case consultation

21,22 ____ Professional community service (talks, advisory groups)

23,24 ____ Other (please specify) _____

2. **How frequently do you engage in each of the following *specific activities* (use scale below)?**

1 = Never
2 = Occasionally
3 = About once a month
4 = About once a week
5 = Several times a week
6 = Once a day
7 = Several times a day

25 ____ Make hospital rounds

26 ____ Perform laboratory procedures

27 ____ Attend continuing education activities

28 ____ Discuss diagnosis and treatment plans with patients

29 ____ Consult with private community physicians or other community health personnel about patients

30 ____ Participate in such preventive programs as immunizations, accident prevention training, ambulance training

31 ____ Work in an emergency room at night or on weekends

32 ____ Develop and/or monitor rehabilitation plans

33 ____ Discuss and/or set medical fees with patients

34 ____ Develop treatment goals and methods of attainment

35 ____ Use medical journals or books as a resource for diagnosis and treatment

36 ____ Consult with medical school physicians about certain patients

37 ____ Participate in a "team approach" to medical care (i.e. where a group of health professionals are involved in developing and monitoring treatment plans)

38 ____ Attempt to involve the family of an identified patient in improving their family health care

39 ____ Fill out insurance and other third party payment forms

40 ____ Schedule and monitor patient follow-up

41 ____ Provide health education information to patients (e.g. nutrition, preventive care etc.)

42 ____ Order equipment or supplies for the site

43 ____ Examine office records (e.g. collections, expenditures, etc.)

44 ____ Attend meetings of local medical organizations

45 ____ Discuss community health needs/goals with local community

3. How frequently do you work or consult with each of the following kinds of health professionals or institutions/agencies (Use same scale as above in question 2)?

46 ____ Nurse practitioner
47 ____ Physician's assistant
48 ____ Physical therapist
49 ____ Laboratory technician
50 ____ Nurse-midwife
51 ____ Visiting nurse
52 ____ Licensed practical nurse
53 ____ Registered nurse
54 ____ Rehabilitation therapist
55 ____ Public health nurse
56 ____ Mental health worker
57 ____ Community health worker
58 ____ Private physicians
59 ____ Health administrative staff
60 ____ Public health clinic
61 ____ Community mental health center
62 ____ Old age facility
63 ____ Welfare/Social Service Department
64 ____ Private hospital
65 ____ Medical school

4. How frequently do you engage in each of the following non-medical activities? (Use same scale as above in questions 2 & 3.)

66 ____ Church activities
67 ____ Community socials
68 ____ Outdoor sports
69 ____ Cultural activities
70 ____ Other outdoor activities (e.g. hiking, rockhounding)
71 ____ Informal social activities with members of site staff
72 ____ Informal social activities with individuals in community

5. During the time you have been at the site, have you become interested in any social/recreational activities which were new to you?

73-1 ____ Yes 73-2 ____ No

If yes, please indicate _____

6. In general, how do you rate this community in terms of its attractiveness with respect to the following (use scale below):

1 = Very unattractive
2 = Moderately unattractive
3 = Slightly unattractive
4 = Neither attractive nor unattractive
5 = Slightly attractive
6 = Moderately attractive
7 = Very attractive

74 ____ A place to practice medicine for a few years
75 ____ A place to set up a long-term medical practice
76 ____ A place for a single physician
77 ____ A place for a married physician
78 ____ A place to bring up a family
79 ____ A place to practice medicine as a private physician
80 ____ A place to practice medicine as an NHSC physician

7. **For each item listed below, please indicate the *extent to which* it is *characteristic* of your present work situation. (Use a 7 point scale where 1 = to no extent, extremely uncharacteristic and 7 = to a great extent, extremely characteristic.)**

card 11

08 ____ Having responsibility for defining one's role, duties and activities

09 ____ Having personal control of the amount of time devoted to patient care

10 ____ Trying out new ideas

11 ____ Sharing patient responsibility with other physicians

12 ____ Maintaining a fairly consistent and predictable patient-scheduling system

13 ____ Dealing with emergency medical problems

14 ____ Having sufficient opportunity for professional advancement

15 ____ Obtaining intellectual stimulation through interaction with colleagues

16 ____ Performing habitual or nonvarying medical activities

17 ____ Having satisfactory coverage for patients during periods of absence

18 ____ Having the opportunity for appreciation and prestige from the lay public

19 ____ Having accessible consultation services

20 ____ Being isolated from other physicians

21 ____ Working with or under a community board or citizens' group

22 ____ Taking less vacation and/or free time than one is entitled to take

23 ____ Maintaining preferred "pace of life"

24 ____ Determining amount of free time and/or vacation time

25 ____ Having an income adequate to fulfill needs of one's "life style"

26 ____ Being burdened with excessive "red tape" in providing adequate medical care

27 ____ Having personal control of the progress of one's medical career

8. **Please indicate the extent to which you agree or disagree with each of the following statements using the scale below.**

1 = Strongly disagree
2 = Moderately disagree
3 = Slightly disagree
4 = Neither agree nor disagree
5 = Slightly agree
6 = Moderately agree
7 = Strongly agree

28 ____ The family physician has unique skills and functions which can't be duplicated by medical specialists or physician extendors

29 ____ Providing total medical care in the context of a patient's family is a good idea, but it doesn't work out well in practice

30 ____ In light of uncertainties about the future forms of health care delivery, a salaried position in a government sponsored delivery system is very attractive

31 ____ Government involvement in health care delivery is bound to create more problems than it solves

32 ____ The primary care physician is likely to feel that the care he provides is second-rate

33 ____ Top-notch modern medicine simply can't be practiced in remote areas given the lack of support facilities and expert consultation

34 ____ The satisfaction of knowing you have provided medical care where little or none existed before, is sufficient motivation for practicing in a remote shortage area

35 ____ The demands on the time of a primary care physician in a remote setting make it impossible for him/her to have a satisfying personal life

36 ____ With medical specialists above him and physician extendors below, not much of an area of expertise is left for the family physician

8. (Continued) Please indicate the extent to which you agree or disagree with each of the following statements using the scale below.

1 = Strongly disagree
2 = Moderately disagree
3 = Slightly disagree
4 = Neither agree nor disagree
5 = Slightly agree
6 = Moderately agree
7 = Strongly agree

37 ___ Isolation from the larger medical community is an important deterrant from practicing in a remote area

38 ___ Patients are likely to be suspicious of physicians who work for the federal government

39 ___ The lack of intellectual and social stimulation in small communities outweighs the appeal of the slower-paced life style

40 ___ Salaries for NHSC physicians will have to be quite a bit higher to attract physicians to the corps

41 ___ A physician who likes to feel he's/she's his/her own boss is likely to be dissatisfied working with NHSC

42 ___ There is little difference between working as a private physician in a shortage area versus working as an NHSC physician in the same place

43 ___ A few years with the NHSC is a good way for a young physician to make up his mind about his/her future career goals

44 ___ Providing primary care in the absence of all the trappings of modern medicine, is exciting and a challenge to the skill and ingenuity of the physician

45 ___ A responsible primary care physician in a remote area will always send his/her more difficult cases to specialists

46 ___ Seeing the results of your treatment is perhaps the most gratifying aspect of providing primary medical care

47 ___ The challenge of being in a position to improve both individual as well as environmental health in a small community, is very appealing

48 ___ Most of the medical problems seen by primary care physicians in small communities are routine and uninteresting

49 ___ The expectations community members have of a local doctor are unrealistic and cannot be fulfilled by a family physician

50 ___ You don't need a high-powered medical school education to adequately treat the majority of problems brought to the primary care physician

51 ___ Outside of work, there isn't much to do in the boondocks

52 ___ The NHSC has treated me fairly

9. Which of the following is your *primary* reason for joining the NHSC?

53-1 ___ CORD deferment
53-2 ___ Scholarship obligation
53-3 ___ Non-obligated service

How long have you been in the NHSC? _____

When did you come to this particular site? _____ (date)

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DO NOT WRITE IN THIS SPACE

Name of preceptee _____ 1 2 3 4 5 6 7

School _____

Site where participating _____ _____ 8 9 10

Name of preceptor _____ 11 12 13 14 15

PRECEPTEE ASSESSMENT

1. **By the end of the preceptorship experience, to what extent did your preceptee demonstrate evidence of: Use a seven point rating scale where 1 = not at all, to no extent and 7 = a great deal, to a great extent. The integers in between represent gradations between these two extremes.** *If you are unable to rate a particular item due to insufficient basis for making an assessment, use a zero (0) to indicate this.*

card 9

16 ____ Knowing methods for managing epidemic disease

17 ____ Knowing the available mechanisms for financing health care

18 ____ Knowing methods for improving public health practices

19 ____ Being able to contribute his own skills and knowledge to the functioning of a health team

20 ____ Knowing how to use other resources for health care available in the community

21 ____ Being sensitive to special health care problems and needs of the elderly

22 ____ Knowing how to disseminate health information to the community at large

23 ____ Being able and willing to seek out medical consultation from less readily available sources outside the community

24 ____ Knowing how patients enter and move through the system of medical care in the community

25 ____ Knowing how to work with community health agencies in the management of particular patients

26 ____ Knowing some of the typical consumer resistances to different forms of health care delivery (e.g., large hospital based)

27 ____ Knowing some of the typical consumer resistances to "modern" health care procedures (e.g., lab technicians, physician extendors)

28 ____ Knowing how to use the special skills and capabilities of physician extendors

29 ____ Skill in working effectively with poorly educated or poorly motivated patients

30 ____ Being able to develop treatment strategies suited to the values and needs of particular ethnic and socio-economic groups

31 ____ Being able to "diagnose" environmental and/or social contributors to illness

32 ____ A willingness to work on health problems at a community program level

33 ____ Knowing what factors are important in making an office practice economically viable

34 ____ Skill in the use and maintenance of office medical equipment

35 ____ Being able to deal with medical emergencies

36 ____ An ability to select appropriate methods for augmenting his/her clinical knowledge

37 ____ Knowing when to admit patients to the hospital

38 ____ Knowing how to use problem-oriented medical records

39 ____ Skill in establishing treatment goals in the context of the family and psychological situation of the patient

40 ____ Knowing procedures for admitting patients to the hospital

41 ____ Knowing how the various elements of a hospital function separately and together

42 ____ Knowing the special features of managing chronic illness

43 ____ Knowing how to work effectively with the facility's governing community board

1. **(Continued) Use a seven point rating scale where 1 = not at all, to no extent and 7 = a great deal, to a great extent. The integers in between represent gradations between these two extremes.** *If you are unable to rate a particular item due to insufficient basis for making an assessment, use a zero (0) to indicate this.*

44 ____ Knowing his/her own strengths and weaknesses in the area of patient interaction

45 ____ Knowing his/her own strengths and weakness in interacting with other health professionals

46 ____ Having changed his attitudes and views about medical care from those he held initially

47 ____ Having changed his own career goals in medicine.

2. **To what extent did the student's presence at the site (Use same rating scale as in (1) above):**

48 ____ Increase the daily work load of the preceptor

49 ____ Decrease the daily work load of the preceptor

50 ____ Increase the work load of other staff members

51 ____ Decrease the work load of other staff members

52 ____ Add to community awareness, knowledge or effectiveness with regard to community health problems

53 ____ Improve health care attitudes and behaviors of individual patients

54 ____ Increase community understanding/acceptance of the NHSC preceptorship

55 ____ Facilitate utilization of medical school faculty consultation on clinical problems

56 ____ Provide community members with a better understanding of the needs and interests of young physicians

57 ____ Provide intellectual stimulation for the preceptor

58 ____ Add to the effectiveness of clinic operations

3. **To what extent were you *satisfied* with your preceptee with regard to each of the following? Use same scale as above where 1 = to no extent, not at all satisfied and 7 = to a great extent, extremely well satisfied.**

59 ____ Taking initiative in exploring his/her own interests in medicine

60 ____ Accepting and utilizing constructive criticism of his/her clinical skills

61 ____ Accepting and utilizing constructive criticism of his/her patient-interaction skills

62 ____ Showing interest in and learning about the economics of office practice

63 ____ Working effectively with community health care facilities

64 ____ Working at a level consonant with his/her level of medical training

65 ____ Getting involved in all aspects of the medical care system

66 ____ Getting involved in the social/recreational activities available in the area

67 ____ Accepting guidance in performing his/her project

68 ____ Understanding and demonstrating the attributes of his/her future role as a physician

69 ____ Acquiring and utilizing knowledge about the appropriate use of community medical and social service consultative resources

70 ____ Being available when needed

71 ____ Willingness to undertake tasks of which I judged him/her to be capable

72 ____ As a preceptee, in general

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Name _____

School _____
Site Where
Participating _____

DO NOT WRITE IN THIS SPACE

_____ _____ _____ _____ _____ _____ _____
1 2 3 4 5 6 7

CAREER RATING AND PREFERENCE QUESTIONNAIRE
POST EVALUATION

card 4

08,09 At this point in your professional development, in what area or specialty of medicine do you plan to work?_____

_____ _____

1. Please rate all of the following areas of medicine in terms of your current inclination or disinclination to practice in them. (Mark the number indicating your opinion in the space provided before the titles.) PLEASE USE THE FOLLOWING SCALE:

1 = Strongly inclined to *avoid*
2 = Moderately inclined to *avoid*
3 = Slightly inclined to *avoid*
4 = Neither inclined nor disinclined
5 = Slightly inclined to *select*
6 = Moderately inclined to *select*
7 = Strongly inclined to *select*

10 _____Allergy
11 _____Anesthesiology
12 _____Basic Medical Science
(e.g., Pharmacology, Physiology)
13 _____Cardiology
14 _____Dermatology
15 _____Emergency Medicine
16 _____Endocrinology
17 _____ Family Medicine
18 _____ Gastroenterology
19 _____General Practice
20 _____General Surgery
21 _____Geriatrics
22 _____Internal Medicine
23 _____Neurology
24 _____Neurosurgery
25 _____Obstetrics-Gynecology
26 _____Opthalmology
27 _____Orthopedics
28 _____Otolaryngology
29 _____Pathology
30 _____Pediatrics
31 _____Physical Medicine and Rehabilitation
32 _____Plastic Surgery
33 _____Psychiatry
34 _____Pulmonary Diseases
35 _____Public Health/Preventive Medicine
36 _____Radiology
37 _____Thoracic Surgery
38 _____Urology

2. Please rate each of the following career settings in terms of your current inclination or disinclination to work in them. PLEASE USE SCALE ABOVE IN #1).

39 _____Private Practice, solo
40 _____Partnership
41 _____Private Practice, Groups:
42 _____Mixed Specialty (e.g. small clinic)
43 _____Team Practice of one specialty
44 _____Large Group (hospital based)
45 _____Government Institutions or Agencies
46 _____VA Hospital
47 _____Military Hospital
48 _____City, State or County Hospital
49 _____City, State, or County Health Department
50 _____Public Health Service (non-hospital based)
51 _____Government Sponsored Health Program
52 _____National Health Service Corps
53 _____Non-government Institutions or Agencies
54 _____Industry
55 _____Private Hospital (staff physician)
56 _____Independent Medical Foundation (e.g. Kaiser Foundation)
57 _____Research Facility (medical school or any of above)
58 _____Educational Institution (e.g. medical school)

3. Assuming a position you obtained allowed for a variety of professional activities, what percentage of your time would you like to devote to (sum of responses should total 100%):

59,60 ____Direct Patient Care
61,62 ____Teaching Medical Personnel
63,64 ____General Administration
65,66 ____Program Planning and Development
67,68 ____Case Consultation
69,70 ____Professional community service (talks, advisory groups)
71,72 ____Supervision of others
73,74 ____Research
75,76 ____Other you would include (please specify):

_____

4. How important do you think each of the following categories of community and work setting characteristics will be in your choice of a position or practice setting after completion of your medical training? Please rate each characteristic on a seven-point scale where 1 = not at all important—will not consider, and 7 = extremely important—crucial to any decision; the integers in between represent gradations of importance between these two extremes.

card 5

OPPORTUNITIES FOR:

8 ____Geographical location
9 ____Size (population)
10 ____Community Economic Status
11 ____Quality of Public School System
12 ____Age Distribution of Population
13 ____Ethnic Distribution of Population
14 ____Political "climate"
15 ____"Pace of Life"
16 ____Distance from a Metropolitan Area
17 ____Distance from a Medical School
18 ____Availability of Support Services (e.g., labs)
19 ____Income/Salary
20 ____Ability to Control Income (e.g., set fees)
21 ____Job Security, Benefits
22 ____Type of Patients or Clients
23 ____Variety of Practice Activities
24 ____Ability to Control Hours
25 ____Ability to Control Patient Load
26 ____Frequency of Need to Meet Emergencies
27 ____Amount of "red tape" involved in carrying out job activities
28 ____Prestige of Organization or Group
29 ____Professional Abilities of Co-workers
30 ____Personal Characteristics of Co-workers
31 ____Amount of Routine Task Activity
32 ____Your preferred cultural, recreational or entertainment activities
33 ____Working in your most preferred type of work setting (please see list, Question #3)
34 ____Your spouse to obtain employment or pursue a career
35 ____Being in a high demand/low supply specialty for the area
36 ____Proximity to persons prominent in your field of medicine
37 ____Part-time affiliation with a Medical School
38 ____"Getting Ahead" Professionally
39 ____Directing others in their work
40 ____Molding one's own roles, duties and activities
41 ____Trying out one's own ideas
42 ____Expanding one's own knowledge in an area of medicine
43 ____Working with other physicians on some joint task
44 ____Working with non-physicians in a Treatment Team
45 ____Other Characteristics (please specify):

_____

5. When you have completed your medical education, would you prefer or not prefer to work in a community with the following characteristics? Please rate each characteristic on a seven-point scale where 1 = strongly inclined to *avoid*, and 7 = strongly inclined to *prefer*.

Location:

46 ____Northeastern United States
47 ____Southeastern United States
48 ____Midwest
49 ____South Central (TX, AR, OK)
50 ____Rocky Mountain States
51 ____West Coast
52 ____Other (please specify): _____

Size of Community:

53 ____Over 100,000 Population (large metropolitan area)
54 ____Suburban Area Adjacent to Large Metropolitan Area
55 ____Population between 50,000 and 100,000 (medium city)
56 ____Population between 10,000 and 49,999 (small city)
57 ____Population less than 10,000 (small town or rural)

Economic Status of Community:

58 ____Poverty Area or Low Economic Status
59 ____Moderate or Mixed Income Area
60 ____Wealthy Community

Typical Life Style or "Pace"

61 ____Community with a "Fast" pace (e.g., New York, Los Angeles, Chicago)
62 ____Community with a "Moderate" pace of life (e.g., Albuquerque, Tucson)
63 ____Community with a "Slow" pace (e.g., Hitching Post, Kansas; Wagon Mound, New Mexico)

Please use the scale below to rate the following items:

1 = Strongly inclined to *avoid*
2 = Moderately inclined to *avoid*
3 = Slightly inclined to *avoid*
4 = Neither inclined or disinclined
5 = Slightly inclined to *select*
6 = Moderately inclined to *select*
7 = Strongly inclined to *select*

6. How inclined would you be to work with the following types of individuals in practicing medicine?

64 ____Nurse Practitioner
65 ____Physician's Assistant
66 ____Physical Therapist
67 ____Laboratory Technician
68 ____Nurse-Midwife
69 ____Health Administrative Staff
70 ____Community Health Worker
71 ____Visiting Nurse
72 ____Licensed Practical Nurse
73 ____Rehabilitation Therapist
74 ____Public Health Nurse

7. How inclined would you be to work as a member of the following kinds of health teams?

75 ____A team where the physician is in authority with several allied health personnel working directly under his supervision.
76 ____A team where each member is given authority to make patient care decisions in his own area of expertise without physician approval.
77 ____A team which functioned under the administration of a citizen's board with physicians and other medical personnel responsible for policy decisions affecting health care delivery.
78 ____A team which functioned under the supervision of a citizen's board with citizens having major input into policy decisions affecting health care delivery.

8. At the point when you are ready to enter practice, would you be interested in having the opportunity to make contact with others who have similar practice interests?

79-1 ____Yes 79-2 ____No

At the point when you are ready to enter practice, would you be interested in obtaining detailed information about existing innovative team/group practice models which have proved successful?

80-1 ____Yes 80-2 ____No

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